

Initial Intakes Assessment (Form S-8)

UC Basic Information



First Name:

AKA:

Last Name:

Status:

Date of Birth:

Admitted Date:

A#:

Length of Stay:

Country of Birth:

Current Program:

Gender:

Portal ID:

Initial Intakes Assessment

INSTRUCTIONS: A staff member trained in the use of this form completes it within 24 hours of the child or youth's admission at the care provider facility. The staff member completing this form must be trained to ask and gather sensitive information in a child-friendly and culturally appropriate manner. This assessment will gather basic identifying information, identify any immediate medical or mental health needs the child or youth has, ensure that the needs are appropriately met, and inform the child or youth's initial housing/bed assignment.

Child's Arrival Date/Time:

Intake Interview Date/Time:

Primary Language:

Intake conducted in:

Other Languages Spoken:

Language	Options
<input type="text" value="--Select Language--"/>	Save

Date of departure from home country:

Date of Arrival in the US (approx.):

Child's Eye Color:*

Family Information

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Do you know anybody in the U.S.?
Include relative and non-relative
contacts in this section.

Name	Relationship	Address	Phone
<input type="text"/>	-- Select Relationship --	<input type="text"/>	<input type="text"/>
<input type="text"/>	-- Select Relationship --	<input type="text"/>	<input type="text"/>
<input type="text"/>	-- Select Relationship --	<input type="text"/>	<input type="text"/>
<input type="text"/>	-- Select Relationship --	<input type="text"/>	<input type="text"/>
<input type="text"/>	-- Select Relationship --	<input type="text"/>	<input type="text"/>

Is there someone we can contact
to let them know you are here?

Medical

If any observed or reported medical concerns are checked in the section below, please immediately report these to the Clinician, Lead Case Manager, Program Director, Shift Supervisor, and/or any on-call medical staff member for further guidance on the need to seek immediate medical care.

Have you experienced any
physical/medical problems today
or in the last 30 days?

Yes No

If yes, please explain:

Have you experienced any
physical/medical problems?

Yes No

If yes, please explain:

Do you have any allergies?

Yes No

If yes, please explain:

Do you have any special dietary
needs?

Yes No

If yes, please explain:

Are you currently taking any prescribed or other medication? If yes, list below. Other medication may include herbal remedies, over-the-counter remedies etc.

Yes No

Medication

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Medication	Dose	Purpose
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Observable or reported medical concerns (Check all that apply).

Concern	Yes/No	
Coughing	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Difficulty Breathing	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Dehydration	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Dizziness	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Confusion	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Fever	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Pregnant	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Exhaustion	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Lice	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Injuries	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Bruises	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Burns	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Scabies	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Vomiting	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Abdominal Pain	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Coughing Blood	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Nausea	<input type="radio"/> Yes <input checked="" type="radio"/> No	

Skin lesions/rash	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Severe/persistent headache	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Jaundice (Yellowing of the skin/whites of eyes)	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Neurological symptoms (Spasm, tics, uncontrollable movements, paralysis or numbness of any part of the body)	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Others(list)	<input type="radio"/> Yes <input checked="" type="radio"/> No	If Yes, specify: <input type="text"/>

If injuries, wounds, bruises present, describe them and how they occurred:

List of other medical concerns:

Have you ever been to a doctor or stayed in a hospital

Yes No

If yes, please list any visit or stay for any reason. Also include visits to other healers or alternative treatment providers:

Do you have a history of tuberculosis?

Yes No

If yes explain:

Do you have a history of seizures or convulsions?

Yes No

If yes explain:

Do you have any scars, birthmarks, or tattoos?

Yes No

(Client should not disrobe to show marks.)

If yes explain:

Mental Health (Check all that apply)

If the child answered "Yes" to any of the below mental health questions and/or if any concerning behaviors or emotions were observed or reported, immediately report your concerns to the Clinician, Lead Case Manager, Program Director, or Shift Supervisor for further guidance on the need to seek mental health care.

Concern	Yes/NO
Tried to hurt yourself?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Had urges to beat, injure or harm someone?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Harmed anyone?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Thought of attempting suicide or hurting yourself?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Attempted suicide?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Heard voices that others do not?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Seen things or people that others do not see?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Had trouble controlling anger or violent behavior?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Are you having thoughts of harming yourself or someone else?	<input type="radio"/> Yes <input checked="" type="radio"/> No

Please explain any checked answers above:

Observable emotional concerns (Check all that apply)

Concern	Yes/NO	
Cooperative	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Uncooperative	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Alert	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Distracted	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Calm	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Excited	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Nervous	<input type="radio"/> Yes <input checked="" type="radio"/> No	

Agitated	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Confused	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Sad	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Angry	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Other	<input type="radio"/> Yes <input checked="" type="radio"/> No	If Yes, specify: <input type="text"/>

Are you having thoughts of harming yourself or someone else?

Safety Assessment

If the child answered "Yes" to any of the below safety assessment questions, immediately report concerns to the Clinician, Lead Case Manager, Program Director, or Shift Supervisor for further guidance on how to ensure the child's safety.

Do you feel safe now? Yes No

If No, explain:

Angry	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Other	<input type="radio"/> Yes <input checked="" type="radio"/> No	If Yes, specify: <input type="text"/>

Are you having thoughts of harming yourself or someone else?

Safety Assessment

If the child answered "Yes" to any of the below safety assessment questions, immediately report concerns to the Clinician, Lead Case Manager, Program Director, or Shift Supervisor for further guidance on how to ensure the child's safety.

Do you feel safe now? Yes No

If No, explain:

Do you fear that someone will harm you? Yes No

If yes, explain:

Explain to the child where the child's room will be located in the facility, the number of potential roommates, the age and sex of the roommates, and the bathroom and shower area associated with the potential room assignment. After having explained this, does he or she identify any specific fears about this potential housing assignment?

Yes No

If yes, explain:

Do you need anything right now?

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INTERVIEWER SUMMARY OF CRITICAL ISSUES THAT NEED IMMEDIATE ATTENTION:

List any issues rated above as urgent or significant and your actions to address them.

Deliver this form to the Lead Case Manager, Clinician, or other SUPERVISOR designated to follow-up care.

ACTIONS TAKEN:

Each action should correspond to the issues noted at left.

1	<input type="text"/>	1	<input type="text"/>
2	<input type="text"/>	2	<input type="text"/>
3	<input type="text"/>	3	<input type="text"/>

Staff Signature:

Date/Time:

Staff Name:

Staff Title:

Translator's Signature:

Date/Time:

Translator's Name:

Language:

Save

Reset