Boles Children's Home
Emergency Shelter and Assessment Center

Initial Admission Packet

I. Child's Information

Name	DOA	Time	DOB	Sex	Race	Hair	Identifying Marks

Ht.	Wt.	Eyes	SS#	Medicaid #	Primary Language	Place of Birth	ST

Religious Preference

II. Placement History:

Name any out-of-home placements (birth forward)	Reasons for Discharge

III. Reason for Placement:

☐ Abandonment ☐ Medical Neglect ☐ Physical Neglect ☐ Sexual Abuse

☐ Emotional Abuse ☐ Neglectful Supervision ☐ Parent/Child Issues ☐ Domestic Violence

☐ At risk due to: ☐ Placement Disruption ☐ Other ______________________________

Recent Housing Status: (govt. assistance, parents rent/own, living with relative/friend)

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History of Homelessness: (explain circumstances) ☐ NA

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Additional circumstances requiring placement: (identify alleged perpetrator)

Has the child received any type of medical exams prior to placement at the Assessment Center? (list reasons, what doctor, who is the Primary Care Physician, what clinic/hospital, & copies)

Does the child have medical insurance? (list and make copy of card)

IV. Any Medications:

Medication	Dosage	Taken for	Doctor

Any special medication instructions or concerns?

Any medications that need refills? (when and where)

Does the child need to have meds followed by a psychiatrist? (who and when)

V. Child's Medical History

Medical Condition	(check)			Comments or Concerns
	yes	no	unk.	
Premature at birth				
Any birth defects				
Birth injury				
Medical treatments at birth				
Hospitalizations at birth, or any age				
Psychiatric hospitalizations, date & where				
Serious injuries after birth, or any age				
Colic or infant distress				
Failure to thrive				
Shaken baby syndrome				
Infant poor nutrition				
Reflux/projectile vomiting				
Eye problems/vision problems				
Frequent ear infections				
Wears glasses				
Hearing loss (which ear and what %)				
Other ear or hearing problems				
Wears hearing aid				
Uses sign language				
frequent nose bleeds				
Nose or sinus problems				
Frequent sore throat, problems				
Chronic lymph node swelling				
Teeth chipped/capped				
Teeth needing fillings				
Dentures, partials, bridges				
Missing permanent teeth				
Mouth sores, canker sores				
Fever blisters, cold sores				
Frequent diarrhea				
Frequent constipation				
Chronic vomiting or nausea				
Stomach aches/abdominal pain				
Stomach ulcers				
Hernias				
Rectal bleeding				
Hemorrhoids				
History of worms or other parasites				
Frequent headaches				
Severe headaches				
Dizzy spells				

Medical Condition	Yes	No	Unk.	Comments or Concerns
tremors				
Blackouts				
Petite seizures				
Grandmal seizures				
Frequent colds				
Mumps				
measles				
Rubella				
Chicken pox				
Whooping cough				
Any other childhood diseases				
Bloody sputum				
Chronic cough				
Rheumatic fever				
Other infectious diseases				
Shortness of breath				
Asthma				
Pneumonia				
Heart murmur				
Other heart condition				
Cardiovascular disease				
Chest pain, angina, or panic attacks				
Blood type				
Blood or bleeding disorder				
Current anemia or history of				
Low blood pressure				
High blood pressure				
Unable to do vigorous exercise				
Gallstones				
Frequent soiling of underwear				Urine / Feces / Discharge
Frequent urinary tract infections				
Bloody urine				
Kidney stones				
Kidney infections				
Enuresis (wetting self or bed)				Daytime / Nighttime
Encopresis (soiling self)				Daytime / Nighttime
Sleep walking				
Athletes foot / foot fungus				
Skin rashes				
Skin lesions or disorder				
Chronic dry skin				
Scabies				
Parasites, ring worm, lice				
Poor appetite				
Over weight/ Under weight				
Recent drastic weight gain/loss				

Medical Condition	Yes	No	Unk.	Comments or Concerns
Growth problems (height)				
Curvature of the spine				
Back problems / injuries				
Nervous system disease				
Paralysis / Numbness				
Swelling of joints / legs				
Arthritis				
Bone deformities or pain				
Thyroid trouble				
Hepatitis (a,b,c)				
Tuberculosis or (exposure)				
Diabetes (family history)				
Asthma (family history)				
Epilepsy (family history)				
Cancer (family history)				
Venereal disease				
Male genital itch (jock itch)				
Uncircumcised hygiene problem				
Penile discharge				
Painful urination				
Urethal discharge				
Period age onset / regular or irregular				
Length of days / frequency				
Difficult period / cramps				
Vaginal discharge				

The child's current health appearance/status: (poor, good, excellent)

Allergies of any kind to: (foods, food intolerance, medicine, substances, animals, etc.)

Any special nutrition or dietary needs: ☐ NA

Child's food likes and dislikes:

Does the child have any developmental delays, physical disabilities, or special needs requiring any special assistance? ☐ NA

Does the child's racial, ethnic religious, or cultural background result in any special services needs? (racial bias, ethnic food desires, needs, cultural, traditions, rituals, routines, religious holidays or special events) ☐ NA

Does the child have a delinquent history or destructive history? (juvenile arrest record, referrals to LCYC, adjudication's, is child follower or leader?) ☐ NA

Does the child have a history of drug, alcohol, or inhalant abuse, use manufacturing, possession and/or delivery? ☐ NA

VI. Behavior Rating Scale	Frequency of behaviors within last six months		
	0	1 or 2	3 or more
Physically assaults peers			
Physically assaults adults			
Verbally or physically threatens people			
Is cruel to animals			
Is cruel, bullying or mean to others			
Talks about killing self			
Deliberately harms self or attempts suicide			
Damages or destroys own possessions			
Damages or destroys possessions of others			
Vandalizes			
Sets fires			
Has documented problems with school work			
Is truant or skips school			
Runs away from home or former placement			
Behaves likes the opposite sex			
Has sexual acting out / sexual play			
Steals at home			
Steals outside the home			
Exhibits strange or bizarre behavior			
Eats or drinks things that are not food			
Masturbates openly or in public			
Hallucinates (☐ auditory, ☐ visual, or ☐ both)			
Wets self during the day (enuresis)			
Wets the bed while sleeping			
Has bowel movements outside the toilet			
Smears or plays with bowel movements			

How typical of the child's behavior?	Not at all	Some what	Very typical
Does not appear to feel guilty after misbehavior			
Expresses feelings that others are out to get him/her			
Lies and/or cheats			
Has quit speaking			
Wishes to be the opposite sex			
Withdraws, does not get involved with others			
Worries excessively, preoccupied with minor annoyances			
Can't concentrate, is easily distracted			
Does not get along or play well with peers			
Expresses feelings of worthlessness			
Prefers playing with ☐ older ☐younger children			
Stares blankly			
Sulks, points, whines			
Acts fearfully or anxiously			
Has trouble sleeping			
Is under active, slow moving, or lacks energy			
Is sad, unhappy, or depressed			
Screams			
Cries ☐ more or ☐ less than usual for age			
Demands attention			
Can't sit still, is restless or hyperactive			
Acts disobediently at home			
Acts disobediently at school			
Gets into fights			
Associates with children who get into trouble			
Swears, cusses, uses obscene language			
Is impulsive, acts without thinking			
Exhibits sudden mood changes			

VII. School Information:

Grade	Former school / Telephone number	Address

Was the child withdrawn from former school? ___________________________________

School Contact person: ____

Former Teacher(s): ____

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Was the child in a classroom for: emotionally disturbed, behavior disordered, speech therapy, any modifications, or any other special educations services?

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What behavior problems did the child have in school?

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What ways did the child do well in school?

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Immunization records: ☐ On file ☐ Need copies ☐ Obtain release

☐ CPS caseworker will obtain copy from school and forward

VIII. Child and family history of dysfunction:

Characteristics of the child or family has experienced	unk	child	mom	dad	maternal grandmother	maternal grandfather	paternal grandmother	paternal grandfather
Domestic violence								
Assaultive behavior								
Runaway behavior								
Suicide								
Substance use								
Substance abuse								
County / state incarceration								
Gang affiliation								
Criminal behavior								
Involving child in criminal behavior								
Mental retardation / low I.Q.								
Mental illness or disability								
Physical illness or disability								
Sexual deviance / offender								
Sexual abuse victim								
Physical abuse victim								
Poor boundaries								
Chronic poverty								
Rigid or inflexible parenting								
Severe controlling parent								
Smothering, lack of individualism								
Enmeshed; few outside involvement								
Social isolation								
Difficult or unable to express feeling								
Frequent family / school moves								
Child moved from one family member to another								
Over concern of psychosomatic complaints								
Lacks discipline skills								
Illiteracy								
Conduct disorder								
Oppositional Defiant Disorder								
Separation anxiety disorder								
Anorexia Nervosa								
Bulimia Nervosa								
Torette's Disorder								
Attachment Disorder								
Attention-deficit Disorder								
Attention-deficit Disorder w/ Hyper								
Schizophrenia								
Bipolar Disorder (manic/depressive)								
Depression								
Post-traumatic Stress Disorder								
Psychiatric Intervention								
Psychiatric Hospitalization								
Marital problems								
Divorce								
Child custody battle								
Other mental health problems								
Developmental delays								
Other:								

IX. Family contacts and other significant support persons:

Name	Relationship	Address	Phone

No contact without Worker's approval   Monitor Contact

Child may send/receive gifts. Mail, phone calls from:

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Child's special interests, sports, talents, hobbies, leisure interests:

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Transportation needs: (to school, medical, therapy, family visits, CPS, etc.)

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Existing appointment Follow-up: (family, medical, therapy, school, CPS, Psych/eval.)

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Will the child need a CARE TEAM sexual abuse evaluation and exam? ☐ **NA**

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Child's typical routine: (eating, bathing, sleeping, homework, schedule)

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Has the child or family been dependent on any type of public assistance? (such as: AFDC, Medicaid, WIC, Food Stamps, Social Security Benefits, VA Benefits, Low Income Housing, etc.)

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Anticipated length of stay: ________ days.

Anticipated discharge plan: (return to parents, relative resource, foster home, basic group home, therapeutic group home, residential treatment center, etc.)

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What type of program will the child need while at our Assessment Center?

☐ Comprehensive Assessment ☐ Emergency Placement Only

Will the child need any of the following services? (check)

☐ Medical Exam ☐ Dental Exam ☐ Vision screening ☐ Hearing Screening

☐ Educational Testing ☐ Psychological Evaluation ☐ Clothing

☐ Developmental Eval. ☐ Psychotropic Meds Follow-up ☐ Group Therapy

☐ Individual Therapy

Child's immediate and most pressing needs:

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How can the Assessment Center best facilitate family reunification and/or adjustment to placement?

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X. Person/Agency Responsible For Placement

Placing Agency or Managing Conservator:

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Representative Name:______________________________ Title:_____________________

Mailing Address: ____

City/State Zip

Phone: daytime (_____)___________________ evening (_____)__________________________

pager (_____)_____________________________ mobile (_____)___________________________

Supervisor: _____________________________________ Title:______________________

Phone: daytime (_____)___________________ evening (_____)__________________________

pager (_____)_____________________________ mobile (_____)___________________________

________________________________ ________________________________

Person completing this form Title
(signature indicates receipts of information)

Date:_____/_____/_____