County of Sonoma

# VALLEY OF THE MOON CHILDREN'S HOME

## INTAKE OBSERVATION CHECKLIST FOR CHILDREN OVER 2 YRS OF AGE

## EMERGENCY FOSTER HOME PLACEMENT

NAME: _____ DOB: _____/_____/_____ ADMIT DATE: _____/_____/_____

### *PHYSICAL*

**BRUISES / WELTS**

**LOCATION:** _____

_____ Of different colors in various stages of healing
_____ In clusters or patterns, possibly reflecting an instrument
_____ Wrap-around wounds

**BURNS**

**LOCATION:** _____

_____ Cigar or cigarette
_____ Glove or stocking type
_____ On genitalia
_____ Patterned burns reflecting use of instrument

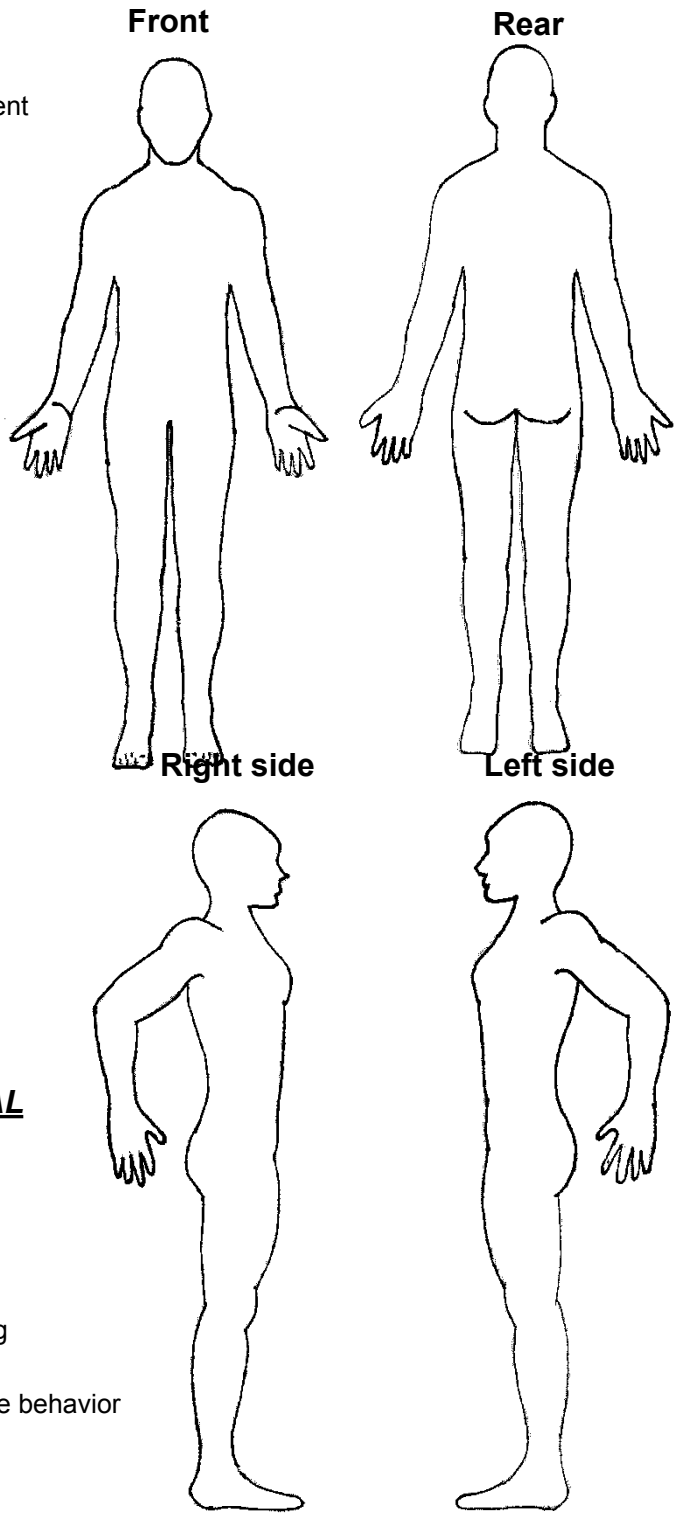
**CONTUSIONS**

**LOCATION:** _____

_____ Swollen or tender limbs
_____ Limited or pained movement of limbs
_____ Lacerations and abrasions
_____ Vomiting

**OTHER CONDITIONS:**

_____ Human bite marks
_____ Bald patches on scalp
_____ Dirty, unkempt appearance
_____ Difficulties in walking or sitting
_____ Complaints of pain, swelling, or itching genitalia
_____ Complaints of painful urination
_____ Pregnancy
_____ Rash
_____ Lice
_____ Appears under nourished
_____ Other: _____




### *BEHAVIORAL*

_____ Excessively wary of physical contact with adults
_____ Excessive aggression, hostility
_____ Appears withdrawn or depressed
_____ Hungry
_____ Listlessness
_____ Complaints of inadequate care, supervision, nurturing
_____ Reluctant to change clothes for shower
_____ Unusually sophisticated sexual knowledge / seductive behavior
_____ Complains of sexual assault
_____ Bedwetting
_____ Talks about, or has attempted suicide (history)

| County of Sonoma | **MEDICAL QUESTIONS** | **YES** | **NO** |
|---|---|---|---|
| 1. | Are you feeling sick? | **YES** | **NO** |
| 2. | Does anything hurt? | **YES** | **NO** |
| 3. | Are your allergic to any medications or anything else? | **YES** | **NO** |
| | If yes, what allergies? | | |
| 4. | Do you have Asthma? | **YES** | **NO** |
| | Do you use an inhaler? | **YES** | **NO** |
| | Do you have it with you? | **YES** | **NO** |
| 5. | Are you currently taking medication? | **YES** | **NO** |
| 6. | What medication are you taking? | | |
| 7. | What medication did you bring with you? | | |
| 8. | Who is your doctor? | | |
| 9. | Do you have any rashes? | **YES** | **NO** |
| 10. | Is there anything that we should know about you medically? | | |
| 11. | Do you have any bruises? | **YES** | **NO** |
| | or scars? | **YES** | **NO** |
| 12. | Have you had any drugs or alcohol with the last 24 hours? | **YES** | **NO** |
| 13. | Do you wear glasses or contacts? | **YES** | **NO** |
| | Do you have them with you? | **YES** | **NO** |
| 14. | When was the last time that you saw a dentist? | | |
| 15. | Are you currently seeing a counselor?<br>If so, who? | **YES** | **NO** |
| 16. | Have you ever been hospitalized in a psychiatric hospital? If yes, where and when? | **YES** | **NO** |
| 17. | Have you ever experienced the loss of a family member or care giver? | **YES** | **NO** |
| 18. | Do you have a history of depression? | **YES** | **NO** |
| 19. | Are you currently feeling depressed? | **YES** | **NO** |
| 20. | Have you ever tried to commit suicide? | **YES** | **NO** |
| 21. | Are you thinking about hurting yourself now? | **YES** | **NO** |
| 22. | Have you ever or are you now hearing voices? | **YES** | **NO** |
| 23. | Visual observation for injuries | **YES** | **NO, CHILD DECLINED** |

ADDITIONAL INFORMATION: _____

_____

_____

_____

Information completed by: _____ Date:_____