



## **Arden House Children's Residential Facility**

### **Intake Assessment Form**

*(Confidential – For Internal Use Only)*

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#### **Client Information**

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Hair Color: \_\_\_\_\_

Eye Color: \_\_\_\_\_

Race: \_\_\_\_\_

Identifying Marks (Scars, Tattoos, Birthmarks, etc.):

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#### **Residential History**

Last Known Address:

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With Whom Did the Child Live at this Address?

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Date of Last Known Residence: \_\_\_\_\_



### **Education History**

Last School Attended: \_\_\_\_\_

Previous Grade Level: \_\_\_\_\_

Current Grade Level: \_\_\_\_\_

Scholastic Performance/Academic Concerns:

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### **Parental Information**

Parent 1 Full Name: \_\_\_\_\_

Parent 2 Full Name: \_\_\_\_\_

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married

Addresses:

Parent 1 Address: \_\_\_\_\_

Parent 2 Address: \_\_\_\_\_

### **Guardian Information**

Guardian's Full Name: \_\_\_\_\_

Guardian's Address: \_\_\_\_\_

Guardian's Phone Number: \_\_\_\_\_



### **Admission Details**

Intended Admission date of Admission: \_\_\_\_\_

Actual Admission date: \_\_\_\_\_ (for completion by Arden House Staff)

Name of Person or Agency Who Placing Child:

\_\_\_\_\_

### **Clinical Information/Cognitive Functioning**

Mental Health Diagnosis (if applicable)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*Please include level of functioning and ability to communicate needs

### **Medical History & Diagnosis (if applicable and include allergies)**

\_\_\_\_\_

\_\_\_\_\_

Primary Care Physician:

\_\_\_\_\_

Medication Management Provider:

\_\_\_\_\_

Last Annual Exam:

\_\_\_\_\_

Last Dental Exam:

\_\_\_\_\_



**Nature of Child's Problems/Presenting Concerns:**

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History of Elopements: Yes No, if yes please explain:

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History of Aggression towards peers or staff: Yes No, if yes please explain:

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History of Pyromania: Yes No, if yes please explain:

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History of property destruction: Yes No, if yes please explain:

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History of suicidal ideations or suicidal attempts: Yes No, if yes please explain:



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Signature of Youth: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of IDHW Case Worker: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Or** Responsible Party

Signature of Case Manager: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Arden House)