

**Florida Network of Youth and Family Services
CINS/FINS Intake Form**

General Information

Client's Name: _____

Client #: _____

Parent/Guardian: _____

Phone: _____

Teen Screen DPS-8 Administered: Yes No **If Yes, attach results and skip to Staff Observations Regarding Youth. below.**

Substance Use Screening

Has the client ever used: Tobacco Alcohol Marijuana Cocaine Other drug (list below)
If yes, explain (*additional screening recommended*)

Is the client currently using or under the influence of alcohol or drugs? YES NO Date of last use _____
If yes, are you currently receiving services for substance use? YES NO (*If NO, additional screening required*).

Risk Screening

- | | | |
|--|-----|----|
| 1. Have you wished you were dead? | YES | NO |
| 2. Have you felt that life was not worth living? | YES | NO |
| 3. Have you felt like hurting yourself? | YES | NO |
| 4. Have you felt like killing yourself? | YES | NO |
| 5. Have you given up hope for your life? | YES | NO |
| 6. Have you ever attempted to harm or kill yourself? | YES | NO |
| 7. Do you hear voices or see things that other people do not see or hear? | YES | NO |
| 8. Are you currently receiving treatment or medication for a mental health disorder? | YES | NO |
| 9. Have you ever seriously considered or attempted to harm or kill others? | YES | NO |
| 10. Are you currently feeling like hurting or killing someone else? | YES | NO |

If yes to any of the above, please explain: _____

NOTE: For ALL clients, if YES to ANY of the questions 1-6 above, conduct full suicide risk screening to determine appropriate course of action per agency policy. For RESIDENTIAL clients ONLY, initiate mental health alert system, place on sight and sound supervision until full risk screening using either SPS or EIDS is completed and follow internal agency policies related to client safety.

Are you currently or do you regularly experience any of the following:

- | | | |
|--|-----|----|
| Feeling extremely sad, hopeless or depressed? | YES | NO |
| Feeling extremely tense, worried, or anxious? | YES | NO |
| Feeling extremely scared, afraid, or panicked? | YES | NO |
| Feel unable to sleep or eat on a regular basis? | YES | NO |
| Feel unable to control your anger to the point that it may result in hurting others? | YES | NO |

If yes to any of the above, please explain: _____

Staff Observations Regarding Youth:

Behavior:	Normal	Hyperactive	Withdrawn	Resistant or aggressive
Speech:	Normal	Rapid	Slow	Slurred or incoherent
Does youth know his/her name?	YES	NO	Does youth know where he/she is?	YES NO
Does youth know today's date?	YES	NO	Does youth know the time of day?	YES NO

Other Observations _____

Staff completing form: _____

Date: _____

Peer/Supervisor Approval: _____

Date: _____

NOTE: COMPLETE PAGE 2 FOR RESIDENTIAL CLIENTS ONLY

Does client have health insurance? YES NO If yes, Company and ID #: _____

Doctor Name/Phone: _____ Dentist Name/Phone: _____

Does the client have any observable injury, illness or health related issues? YES NO
If yes, explain: _____

Does the client currently have any medical, dental or health conditions or concerns? YES NO
If yes, explain: _____

Has the client been treated or hospitalized for any medical condition(s) in the last year? YES NO
If yes, explain: _____

Is the client currently taking any medication(s)? YES NO
If yes, list all medication _____

Does the client have any allergies (general, food or medication)? YES NO
If yes, list: _____

Does the client have any dietary restrictions, nutritional concerns or fitness issues? YES NO
If yes, explain: _____

(If YES to any of the above, supervisory consultation and/or notification may be required depending on agency policy)

Physical Health Screening (circle all that apply)

- | | | | | |
|-----------------------|-----------------------|------------------------------|--------------|------------------|
| Asthma* | Hemophilia* | Heart Condition* | Diabetes* | Other Not Listed |
| Head Injury (recent)* | Seizures/Blackouts* | Tuberculosis* | Pregnancy* | |
| Hepatitis | Eating Disorder | Fainting/Dizziness | Epilepsy | |
| High Blood Pressure | Gynecological Problem | Sexually Transmitted Disease | Disability | |
| Chronic Headaches | Vision Problem | Chronic Cough | Skin Rashes | |
| Kidney Problem | Digestive Problem | Hearing Problem | Chronic Pain | |

If yes, explain: _____

(Indicates that medical follow-up is required. Initiate medical alert system and follow agency policy on notification)*

Client Room Assignment

Age: _____ Gender: _____ Height: _____ Weight: _____ Build: _____

- | | |
|--|--|
| ____ History of criminal offenses/delinquency | ____ History of sexual assault or misconduct |
| ____ History of assault or aggressive behavior | ____ Chronic runner or previous client |
| ____ History of or current gang affiliation | ____ History of mental health/substance use issues |

Attitude/Cooperation (1 negative/10 positive) 1 2 3 4 5 6 7 8 9 10
Room Assigned: _____ Bed Assigned: _____

Summary observations/comments: _____

Staff completing form: _____ Date: _____

Peer/Supervisor Approval: _____

Date: _____