

### ChildServe Community Program Application

Child Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date last visited: \_\_\_\_\_

Other Physician Consultants/Specialists Supporting Your Child: \_\_\_\_\_

\_\_\_\_\_

## MEDICAL HISTORY

Recent Hospitalization:  No  Yes, dates \_\_\_\_\_ through \_\_\_\_\_

Reason: \_\_\_\_\_

New Condition  No  Yes, specify: \_\_\_\_\_

Prior Hospitalizations/Surgeries (Dates/Reason): \_\_\_\_\_

Other Evaluations/treatments: \_\_\_\_\_

\_\_\_\_\_

**Pregnancy/Birth History:** Full term (38-40 weeks)  Yes  No If no, how many weeks premature: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Prolonged jaundice  Yes  No Health problems first 2 weeks: \_\_\_\_\_

Is the child adopted:  No  Yes When: \_\_\_\_\_ Do you have info re: pregnancy/birth  Yes  No

Overall health of pregnancy:  Good  Fair  Poor Birth Complications  Yes  No Type \_\_\_\_\_

Drug use during pregnancy:  No  Yes Type:  Prescribed  Recreational \_\_\_\_\_

Alcohol use during pregnancy:  None  Occasional use  Moderate use  Heavy use

**Allergies:**  None known  Penicillin  Eggs  Milk Products  Pollen  Sulfa  Aspirin  
 Latex  Peanuts  Other: \_\_\_\_\_

**Immunizations:** (Check if current) (You may be asked to supply an immunization record):

DPT  DT  MMR  Measles  Mumps  Rubella  Polio  HBV  Hib  Chicken Pox

Any allergic reactions to immunizations: \_\_\_\_\_

**Screenings:** TB skin test:  No  Yes If yes, date and results: \_\_\_\_\_

Lead screening:  No  Yes If yes, date and results: \_\_\_\_\_

Other (specify): \_\_\_\_\_

**Childhood Illnesses/Conditions:** (Check all that apply and explain in comments)

Condition	✓	Date	Condition	✓	Date	Condition	✓	Date
Apnea			Headaches			Rubeola		
Asthma			Hepatitis			Scarlet Fever		
Bleeding Problems			HIV			Seizures		
Burn(s)			Lead poisoning			Sickle Cell		
Cardiovascular			Mumps			Sinusitis		
Chickenpox			Nausea/Vomiting			Skin problems		
Conjunctivitis			Neurological issues			Spasms (muscular)		
Contractures			Nosebleeds			Strep Throat		
Diabetes			Pain			Thrush		
Diarrhea			Pica			Tonsillitis		
Ear Infection			Pneumonia			Whooping Cough		
			Rheumatic Fever					

Please explain / comment on all ✓

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Neurological concerns (balance, reflexes, etc):
Seizure Plan (put NA if not applicable):
Pain Management (put NA if not applicable):
Cause of your child's pain
Does your child have chronic pain?
How does your child demonstrate he/she is in pain?
What is your child's threshold for pain?
How do you manage your child's pain?
Any additional medical history information:

**MEDICATIONS**

Please list all medication that your child is currently taking:

<i>Current Medication</i>	<i>Dose</i>	<i>Frequency</i>	<i>Reason</i>

Special Instructions: \_\_\_\_\_  
 Signs and Symptoms your child exhibits when he/she is sick: \_\_\_\_\_

**NUTRITION**

Current Weight \_\_\_\_\_ Current Height \_\_\_\_\_ Appetite:  Good  Fair  Poor  
 In the past 3-6 months has there been a weight change?  No  Lost Weight  Gained Weight  
 Number of pounds \_\_\_\_\_ Reason for weight change \_\_\_\_\_  
 How does your child eat?  By mouth  Feeding tube: given by:  Gravity  P ump  
 If feeding tube, size and type: \_\_\_\_\_ Type of formula: \_\_\_\_\_  
 How many meals per day does your child take and how many snacks? Meals: \_\_\_\_\_ Snacks: \_\_\_\_\_  
 Size and texture of food:  Regular  Bite Size  Chopped  Ground  Pureed  Liquid  Thickened liquid  
 Fluids:  Encourage fluids (amount) \_\_\_\_\_  Limit fluids (amount) \_\_\_\_\_  
 What level of assistance your child needs?  Feeds Self  Needs some assistance  Needs complete assistance  
 Type of assistance? (specify) \_\_\_\_\_

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At mealtime does your child have problems:  Chewing  Swallowing  Choking  None

Does your child have problems with any of the following?  Vomiting  Gagging  Reflux

List some of your child's favorite foods: \_\_\_\_\_

List some of the foods he/she dislikes: \_\_\_\_\_

Are there any other special limitations or concerns related to the food your child may eat? (religious/cultural/doctor's order, etc) \_\_\_\_\_

Special instructions and equipment needs: \_\_\_\_\_

### SENSORY

(Check any areas that apply to your child and explain)

Vision:  Glasses  Contacts (R/L)  Legally blind  Cataracts  Infections  
 Other \_\_\_\_\_

Hearing:  Hard of Hearing (R/L)  Deaf (R/L)  Hearing Aid (R/L)  Cochlear Implant  
 Able to hear but limited/lack of response to verbal input  Screened by \_\_\_\_\_

Other: Child is sensitive to:  Light  Sound  Smell  Touch  Movement  Fabrics  
Explain \_\_\_\_\_  
 Child has unusually high activity level

Special instructions/concerns \_\_\_\_\_

### MOBILITY

My child is able to:  Roll over  Sit  Crawl  Walk  Run  
Concerns:  Balance  Coordination  Other \_\_\_\_\_  
Assistance Needed:  Stand by  Hands on  Assistive Device \_\_\_\_\_

Special Instructions and equipment needs \_\_\_\_\_

### COMMUNICATION

Primary communication:  Verbal  Signs  Facial expression  Pictures  Equipment Type: \_\_\_\_\_

My child is able to:  Follow simple commands  Communicate needs  Use words and sentences effectively

Please check any items that concern you:

Language comprehension  Child becomes frustrated with communication  Not using words or sentences

Ways your child communicates their wants and needs: \_\_\_\_\_

Special Instructions and equipment needs: \_\_\_\_\_

### COGNITIVE/EDUCATIONAL

Has your child developed according to developmental milestones and well child check visits?  Yes  No

Do you/have you had concerns about your child's development?  Yes  No If yes, please explain: \_\_\_\_\_

If in school, what grade is your child in? \_\_\_\_\_ Is your child functioning at grade level?  Yes  No  
If no, please explain: \_\_\_\_\_

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Has your child ever had psychological testing:  Yes  No If yes, please explain: \_\_\_\_\_

Does your child have or had an IEP (Individual Education Plan)?  Yes  No If yes, please explain: \_\_\_\_\_

**SOCIAL/EMOTIONAL**

Describe your child's reaction to new situations or change: \_\_\_\_\_

How does your child indicate enjoyment of an activity: \_\_\_\_\_

What are his/her favorite toy/activities: \_\_\_\_\_

Describe your child's usual mood: \_\_\_\_\_

Do you have concerns about your child's opportunities for socialization? \_\_\_\_\_

Please check any of the following that apply to your child:

- Enjoys interactions with peers  Enjoys interactions with adults  Prefers objects to people

Behaviors or emotions that you or others may be concerned about:

- Hyperactivity  Hits/slaps self  Hits others  Scratches self/others  Bites (self/others)
- Screams  Uses obscene language/gestures  Bangs head  Pulls hair (self/others)
- Self stimulates (rocks, twirls, flaps arms)  Withdrawn  Property Destruction
- Depression  Fear  Anger  Mood swings  Grief

What things have been helpful in supporting your child's behavior? \_\_\_\_\_

**DAILY ROUTINE**

(Check all that apply to your child)

My child is able to:  Wash face  Wash hands  Brush teeth  Comb hair  Bathe  
 Dress him/herself  Manage fasteners (snaps, zippers, buttons)

Any assistance needed: \_\_\_\_\_

Toileting assistance needed:  Independent  Needs some assistance  Requires complete assistance

Special instructions and/or equipment needs: \_\_\_\_\_

**STRENGTHS/NEEDS AND HOPES/DREAMS**

Describe your child's strengths: \_\_\_\_\_

Describe your child's needs: \_\_\_\_\_

What are your child's hopes and dreams?

Short term: \_\_\_\_\_

Long term: \_\_\_\_\_

What are your hopes and dreams for your child?

Short term: \_\_\_\_\_

Long term: \_\_\_\_\_

**SAFETY**

Do you have any concerns about your child's safety?  Yes  No If yes, please explain: \_\_\_\_\_

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Is the child's home environment safe?  Yes  No If no, Please explain your concerns: \_\_\_\_\_

Does your child require a lot of supervision for safety?  Yes  No If yes, please explain: \_\_\_\_\_

Does your child often leave supervision (wander off, run from supervising adult, hide):  Yes  No  
 If yes, Please explain: \_\_\_\_\_

**CHILD'S SUPPORT SYSTEM**

Healthy families are important to a child's development. Helping us understand your family and the resources available to you help ChildServe better understand your child's needs and how we might support you and your child.

**Family Unit:**

1. Who does the child live with?	Check as many as apply: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent (s) <input type="checkbox"/> Other (please identify): <input type="checkbox"/> Siblings How many?
2. Who has legal custody of the child?	Check as many as apply: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent (s) <input type="checkbox"/> Other (please identify):
3. What other family members are important to the child?	Please list them and their names: (include age of siblings)

**Other Natural Supports:**

Community activities important to your child:  church/synagogue/mosque  YMCA  Camp  
 After school peer groups  Other: \_\_\_\_\_

What other people are important to your child? \_\_\_\_\_

**Formal Community Supports:**

Please indicate which other organizations support your child:

AEA: \_\_\_\_\_ Case Management Agency: \_\_\_\_\_  
 Homecare: \_\_\_\_\_ DHS worker: \_\_\_\_\_  
 School District/Name: \_\_\_\_\_ Medical Equipment: \_\_\_\_\_  
 Preschool: \_\_\_\_\_ Childcare center: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Family Resources:**

Employment Income:

<\$20,000  \$20-30,000  \$30-40,000  \$40-50,000  \$50-75,000  \$75,000

Place of employment: Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

Other sources of income:  SSI  SSDI  Family Support Subsidy Alimony  Child Support

**Transportation Needs to Access Services and Supports:**

\_\_\_\_\_  
 \_\_\_\_\_

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**Other support needs:**  Housing  Food  Heat  Safety (domestic violence or abuse?)  Health insurance

**Spiritual or cultural considerations/needs:**

What would you consider to be your child's source of hope, strength, comfort and peace? \_\_\_\_\_

Are there specific restrictions or practices (religious, spiritual, cultural) we should know about in helping/supporting your child in our services? \_\_\_\_\_

### ADDITIONAL INFORMATION

(Please indicate any other information about your child you wish to add)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### SERVICES

Please indicate any of the following services you may be interested in or would like to learn more about:

- Homecare     Respite     Therapy     Childcare     Adaptive Equipment  
 Case Management     Residential Services     SCL

\_\_\_\_\_  
 Signature of Parent/Guardian Date Completed

*(For Internal Use)*

Intake Representative Review		
Additional Information Obtained:		
Service Recommendations		
Service	✓	Comments
Homecare		
Respite		
Therapy		
SCL		
Case Management		
Adaptive Equipment		
Childcare		
TCU		
CCU		
Homes		
Other		

Recommendations reviewed with Family Date: \_\_\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Intake Representative Signature Date