

Child Shelter Client Information

Agency (shelter) _____
 SSN _____
 First Name _____
 M.I. _____
 Last Name _____
 Address _____
 Apt. _____
 City _____
 State _____ Zip _____
 County _____
 #ID _____

Intake Date _____ Time _____

Female Male

Race/ Ethnicity

? African American

? Asian

? Hispanic

? Native American

? White

? Multi-Racial

Urban Suburban Rural n. a.

Grade _____

Birth Date _____ Age _____

Mother _____

Father _____

Transferred (did not spend the night) ___

Tab 2

Child has Experienced

- ? Anger/hitting/biting
- ? Avoidance of physical activity
- ? Bed wetting
- ? Fears
- ? Frequent absences from school
- ? Genital/anal bleeding
- ? Genital/anal bruises
- ? Genital/anal discomfort
- ? Nightmares
- ? Sexual behavior
- ? Sleeplessness
- ? Speech difficulty

Types of Abuse Experienced

- ? Confinement
- ? Physical
- ? Verbal/emotional/psychological
- ? Destruction of property
- ? Rape/sexual
- ? Weapons threatened or used

Child Abuse Witnessed yes no n.a.
 Child Abuse Reported yes no n.a.
 Child in counseling yes no n.a.
 Child in Special Education yes no n.a.
 Child is Disables yes no n.a.

Notes

Previous shelter _____

Previous shelter here yes no n.a.

Last Departure from this shelter

Date _____

Release record? yes no