MK Place Intake Information

Admission Date:	
Admission Time:	

Client Information:

Client's Full Name: (First, Middle, Last)			
Social Security Number:		Place of Birth:	
Age:		Date of Birth:	
Height:		Weight:	
Race/ethnicity:		Gender:	
Hair Color:		Eye Color:	
Religious Preference:		Marital Status:	
Identifying marks: (birthmarks, tattoos, scars)			

Information of Person Placing the Child:

Full Name:	
Address, city, state, zip:	
County:	
Home Phone:	
Relation:	

With whom does the client live with (if not parent or guardian):

Full Name:	
Address, city, state, zip:	
County:	
Home Phone:	
Relation:	
Additional family dynamics described: (Who is involved in the client's care):	

FAMILY INFORMATION

Parent Info

	Natural mother	Step-parent	Natural father	Step-parent
Name				
D.O.B.				
Address				
City/State/Zip				
Home Phone				
Occupation				
Work Phone				
Religious Pref.				
Deceased				
If Yes, Date				
Place				
Marital Status				

Guardian Info

	Relation:	Relation:
Name		
D.O.B.		
Address		
City/State/Zip		
Home Phone		
Occupation		
Work Phone		
Religious Pref.		
Deceased		
If Yes, Date		
Place		
Marital Status		

Family information continued:

Siblings

NAME	AGE	RELATION

Emergency Contact Information: *(Please list someone that does not live with you)*

Name	
Relation	
Address	
City/State/Zip	
Home Phone	

LIST ALL PREVIOUS OUT-OF-HOME PLACEMENTS

(Any institutions: Juvenile detention, Foster care, Rehab, Hospitals, Behavioral health institutions, etc.)

Name of Placement	Address, City, State, Zip	Date(s)

MEDICAL INFORMATION

Name of last doctor seen: (primary care provider)		Date of last visit:	
Adress of clinic: (Address, City, State, Zip)		Phone number:	
Name of medication manager: (if applicable)		Date of last visit:	
Adress of clinic: (Address, City, State, Zip)		Phone number:	
Name of last dentist seen:		Date of last visit:	
Adress of clinic: (Address, City, State, Zip)		Phone number:	
Name of last eye doctor seen:		Date of last visit:	
Adress of clinic: (Address, City, State, Zip)		Phone number:	

Do you have any allergies (pollen, medication, food)? ☐ Yes ☐ No

If yes, please list:	

Do you have any medical concerns or problems at this time? ☐ Yes ☐ No

If yes, describe:	

Insurance info:

PHYSICAL STATE:

Hair:	OK ☐	Not OK ☐
Face:	OK ☐	Not OK ☐
Eyes:	OK ☐	Not OK ☐
Body:	OK ☐	Not OK ☐
Arms:	OK ☐	Not OK ☐
Hands:	OK ☐	Not OK ☐
Fingers:	OK ☐	Not OK ☐
Feet:	OK ☐	Not OK ☐
Legs:	OK ☐	Not OK ☐

Overall comments:

MEDICATIONS

Do you take any medication(s), either prescription or over the counter on a regular basis?

☐ Yes ☐ No

If yes please list medication(s):

Medication Name and Dose	Count

I verify the medications, dosage, and the count are accurate.

Client Signature: _____ Date: _____

REVIEW OF PAST MEDICATIONS

Have you taken medications in the past? If yes, please list them in the table below.

Name and dose of medication	Prescribing doctor	Efficacy (if meds worked)	Side effects or adverse reactions: (if any)

I verify the review of my past medications is correct.

Client Signature: _____ Date: _____

EMOTIONAL STATE

Have you had any recent depression?	Yes ☐	No ☐
Do you have issues with anger?	Yes ☐	No ☐
Have you been having suicidal thoughts?	Yes ☐	No ☐
If yes do you have a plan?	Yes ☐	No ☐
Have you ever attempted suicide?	Yes ☐	No ☐
If yes were you hospitalized?	Yes ☐	No ☐
Have any family members attempted or completed suicide?	Yes ☐	No ☐

Overall comments:

Simple Screening instrument for Infectious Diseases

Client Name:	Date:

	Yes	No
1. Have you seen a doctor or health care provider in the past three (3) months?	☐	☐
2. Have you lived on the street or in a shelter?	☐	☐
3. Have you ever been to jail?	☐	☐
4. Have you ever been told you have a positive HIV test?	☐	☐
5. Have you ever had a positive skin test for TB? A test where you get a shot In your forearm and a few days later a hard bump like a blister appeared?	☐	☐
6. Have you ever been told you have TB? Has anybody you know or lived with been diagnosed with TB in the past year?	☐	☐
7. Are you pregnant? If yes, date of last prenatal examination and due date:	☐	☐
8. Have you missed your last two (2) periods?	☐	☐
9. Within the last thirty (30) days, have you had any of the following symptoms lasting more than two (2) weeks?		
a. Fever	☐	☐
b. Drenching night sweats that were so bad you had to change your clothes/sheets	☐	☐
c. Productive cough	☐	☐
d. Coughing up blood	☐	☐
e. Shortness of breath	☐	☐
f. Lumps or swollen glands in the neck or armpits	☐	☐
g. Losing weight without meaning to	☐	☐
h. Diarrhea lasting more than a week	☐	☐
10. Do you live with someone or are you close to someone who has any of the above symptoms?	☐	☐

Simple Screening instrument for Infectious Diseases

	Yes	No
11. Do you or have you used needles to shoot drugs?	☐	☐
12. Do you use coke, crack, meth and/or heroin?	☐	☐
13. In the last (6) six months, have you had any venereal diseases, sexually transmitted diseases, (like syphilis, gonorrhea, Chlamydia, or nongoncoccal urethritis, trichomoniasis)?	☐	☐
14. Have you, or anyone you've had sex with, had any of the following symptoms within the last thirty (30) days?		
a. Sore or ulcer on the penis or vagina?	☐	☐
b. Rash, spots, or other skin problems, especially on your palms or the Soles of your feet?	☐	☐
Women: Pain when you have vaginal sex?	☐	☐
Men: Unusual discharge from the penis?	☐	☐
15. Have you had sex with more than two (2) people – at different times – in the Past (6) months (with or without a condom)?	☐	☐
16. In the past six (6) months, have you had sex with someone in return for Anything like money, alcohol, or other drugs, a place to stay, or just to survive?	☐	☐
17. Have you been forced to have sex against your will?	☐	☐
18. Do you have hepatitis?		
a. If yes, what type?		

I understand that MK Place will follow Idaho Health Department reporting laws for any suspected communicable diseases.

Yes _____ **No** _____

To the best of my knowledge, I do not have any of the communicable or infectious diseases at this time. This screening has reviewed with my by BYF staff.

Client Signature: _____ Date: _____

BYF Staff Signature: _____ Date: _____

Infectious Disease Testing and Referral Information

Have you ever been tested for the following:

	Yes	No
HIV	_____	_____
TUBERCULOSIS	_____	_____
HEPATITIS A-C	_____	_____

If you answered yes to any of the above, please provide the following information:

Location of testing: _____ Date of Testing: _____

What were you tested for? _____

Did you test positive? Yes ____ No ____

If you answered yes, please explain:_____

Referral Information

Listed below is the location where you can be tested for HIV, TB, and Hepatitis A-C

Physicians Immediate Care or Physicians Optimal Health

495 Yellowstone Ave
Pocatello, Idaho 83201
PIC 208-478-7422 POH 208-425-1620

Southeastern Idaho District Health Department

1901 Alvin Ricken Drive
Pocatello, Idaho 83201
208-233-9080

I have received a copy of this information and recommendation.

_____ _____
Client Signature Date

_____ _____
Bannock Youth Foundation Staff Signature Date

REFERRAL INFORMATION:

Probation officer name:	
Address:	
City, state, zip code:	
Phone number:	
Email address:	

Case worker name:	
Address:	
City, state, zip code:	
Phone number:	
Email address:	

Reason for Referral:

In your own words describe why you are here for residential treatment?

SCHOOL INFORMATION

Please check the academic pathway you are pursuing:

☐ GED

If you have passed any GED tests already, state which you have passed:

☐ Junior or Senior High School:

Name of last school attended:	
Address:	
City, state, zip code:	
Phone number:	
Fax number:	
Current grade:	
Academic guidance counselor's name:	

Have you ever been enrolled in ICON before?

Yes ☐ No ☐

Do you have an IEP or 504?

Yes ☐ No ☐

If yes, please bring a copy of your IEP or 504 to your intake

FOR OFFICE USE:

Date Enrolled:

Program enrolled in *(Students are required to be enrolled within 5 school days from intake date):*

☐ICON ☐GED ☐OTHER _____

Information in preparation for Service Plan

Client Name: _____ **Date:** _____

Parent and/or Guardian

What concerns would you like addressed during your child's stay at M.K. Place?

_____

_____

_____

_____

Email: _____

Phone: _____

Parent and/or Guardian Signature: _____

Client

What concerns or issues would you like to address during your stay at M.K. Place?

_____

_____

_____

_____

Other Concerned Party

Relationship to Client: _____

What concerns would you like to see the client work on during his/her stay at M.K. Place?

_____

_____

_____

_____

Probation officer's name: _____

Probation officer's phone number: _____

Probation officer's email _____

VISIT AND PHONE CONTACT LIST

Phone calls are to family only- no friends or significant others

CLIENT NAME: _____

Relationship to Client	First and Last Name	Phone Number

This list may only be modified by counselor or supervisor