MISSOURI FIRST STEPS
INTAKE INFORMATION WORKSHEET
The following information is necessary to complete the child's electronic record.

CHILD'S LEGAL NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH
SERVICE COORDINATOR NAME	**DATE COMPLETED**

CHILD INFORMATION

Nickname (AKA Name):

Mailing Address:

County: School District:

Race *(check all that apply):*
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White

Ethnicity:
Hispanic/Latino ☐ Yes ☐ No

Language:
Translator/Interpreter Needed: ☐ Yes ☐ No

PRIMARY CONTACT INFORMATION

First Name: Last Name:

Physical Address: Mailing Address:

Phone: (home/cell/work/other) Alternate Phone: (home/cell/work/other)

Ok to Text? ☐ Yes ☐ No E-mail Address:

Preferred Method of Contact: Best Time of the Day:

ALTERNATE CONTACT INFORMATION (OPTIONAL)

First Name: Last Name: Relationship to child:

Address: Household Member: ☐ Yes ☐ No

Phone: (home/cell/work/other)

HOUSEHOLD INFORMATION

Name	Nickname	Relationship to Child	Role (HOH, EDM)

CHILD NAME	DATE OF BIRTH

PRIMARY PHYSICIAN

Physician Name: Phone Number: Fax:

Address: Date last seen:

Obtain ROI for this source: ☐ Yes ☐ No

OTHER PHYSICIAN

Physician Name: Phone Number: Fax:

Address: Date last seen:

Obtain ROI for this source: ☐ Yes ☐ No

BIRTH HISTORY

☐ Foster child ☐ Adopted

Birth Weight (grams): Gestational Age (at birth):

Medical Conditions/General Health:

VISION INFORMATION	HEARING INFORMATION
Has the child had a recent vision test? ☐ Yes ☐ No If Yes, date of exam: ☐ Unknown Doctor Name: ☐ Unknown Results: ☐ Pass ☐ Fail ☐ Follow-up needed ☐ Unsure	Has the child passed the Newborn Hearing Screening? ☐ Yes ☐ No ☐ Unknown Has the child had a recent hearing test? ☐ Yes ☐ No If Yes, date of exam: ☐ Unknown Doctor Name: ☐ Unknown Results: ☐ Pass ☐ Fail ☐ Follow-up needed ☐ Unsure
Family history of eye condition (other than glasses)? ☐ Yes ☐ No If Yes, describe:	Family history of permanent childhood hearing loss? ☐ Yes ☐ No If Yes, describe:
Parent/Caregiver concern or observations:	Parent/Caregiver concern or observations:

CHILD NAME	DATE OF BIRTH

DISCUSSION OF DEVELOPMENT

Recent developmental screening/test? ☐ Yes ☐ No If Yes, by whom:

Date: Results:

PARENTS AS TEACHERS

Enrolled with PAT: ☐ Yes ☐ No If Yes, Parent Educator Name:

Obtain ROI for this source: ☐ Yes ☐ No

CHILD CARE

Enrolled in Child Care: ☐ Yes ☐ No

If Yes, Child Care Provider Name and Location:

Attendance: M T W TH FRI SA SU Hours:

Obtain ROI for this source: ☐ Yes ☐ No

MO HEALTHNET /MEDICAID

Does the child have Medicaid? ☐ Yes ☐ No
Complete the Consent to Use MO HealthNet/Medicaid form for each child, regardless of the child's Medicaid status.

MISCELLANEOUS INFORMATION