

**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
INTAKE SERVICE COORDINATOR NAME	DATE COMPLETED

CHILD INFORMATION	
Nickname (AKA Name):	
Mailing Address:	
County:	School District:
Race (check all that apply):	Ethnicity:
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No Language: Translator/Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No

PRIMARY CONTACT INFORMATION			
First Name:	Last Name:		
Physical Address:			
Home Phone:	Work Phone:	Mobile Phone:	Mobile Phone:
E-mail Address:	Ok to Text? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Preferred Method of Contact:	Best Time of the Day:		

ALTERNATE CONTACT INFORMATION			
First Name:	Last Name:	Relationship to child:	
Address:		Home/Mobile Phone:	

HOUSEHOLD INFORMATION			
Name	Nickname	Relationship to Child	Role (HOH, EDM)
PARENT:			
PARENT:			

CHILD NAME		DATE OF BIRTH	
PRIMARY PHYSICIAN			
Physician Name:		Phone Number:	Fax:
Address:		Date last seen:	
Obtain ROI for this source: <input type="checkbox"/> Yes <input type="checkbox"/> No			
OTHER PHYSICIAN			
Physician Name:		Phone Number:	Fax:
Address:		Date last seen:	
Obtain ROI for this source: <input type="checkbox"/> Yes <input type="checkbox"/> No			
BIRTH HISTORY			
<input type="checkbox"/> Foster child <input type="checkbox"/> Adopted			
Birth Weight (grams):		Gestational Age (at birth):	
Medical Condition(s):			
Comments:			
VISION INFORMATION		HEARING INFORMATION	
Child has had a vision test? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has the child passed the Newborn Hearing Screening?	
If Yes, date of exam:		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Doctor Name:		Child has had a recent hearing test? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Doctor Phone:		If Yes, date of exam:	
Results: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Follow-up needed <input type="checkbox"/> Unsure		Doctor Name:	
		Doctor Phone:	
		Results: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Follow-up needed <input type="checkbox"/> Unsure	
Family history of eye condition (other than glasses)?		Family history of permanent childhood hearing loss?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe:		<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe:	
Parent/Caregiver concern or observations:		Parent/Caregiver concern or observations:	

CHILD NAME	DATE OF BIRTH
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DISCUSSION OF DEVELOPMENT

Recent developmental screening/test? Yes No If Yes, by whom:
Date: Results:
Comments:

PARENTS AS TEACHERS

Enrolled with PAT: Yes No If Yes, Parent Educator Name:
Phone Number:
Frequency of Visits:
Obtain ROI for this source: Yes No

CHILD CARE

Enrolled in Child Care: Yes No
If Yes, Child Care Provider Name and Location:
Phone Number:
Attendance: M T W TH FRI SA SU Hours:
Obtain ROI for this source: Yes No

MISCELLANEOUS NOTES