

CHILD INTAKE

(TCU WOMEN AND CHILDREN RESIDENTIAL FORMS)

CODE A-H WITHOUT QUESTIONING RESPONDENT:

[FORM 316; CARD 01]

A. SITE:	_	[6]
B. CHILD ID NUMBER:	_ _ _ _ _ _ _	[7-10]
C. MOTHER ID NUMBER:	_ _ _ _ _ _ _	[11-14]
D. DATE OF THIS INTERVIEW:	_ _ _ _ _ _ _	[15-20]
	MO DAY YR	
E. NAME OF INTERVIEWER: _____	_ _ _ _	[21-22]
	ID#	
F. DATE OF ADMISSION:	_ _ _ _ _ _ _	[23-28]
	MO DAY YR	
G. ASSIGNED COUNSELOR ID NUMBER:	_ _ _ _	[29-30]
	ID#	
H. CHILD GENDER:	0=Female 1=Male	[31]

I want to ask you some specific questions about your children. [INSTRUCT CLIENT TO NAME ONE CHILD AND ANSWER ALL QUESTIONS WITH THAT CHILD IN MIND. USE A SINGLE FORM FOR EACH CHILD. BEGIN WITH THE CHILDREN WHO ARE IN TREATMENT WITH THE MOTHER.]

1. What is the child's current age and birthdate? Age: |_|_| [32-33]

Date of Birth: |_|_|_|_|_|_|_|_| [34-39]

MO DAY YR

2. What is the child's race or ethnic background? |_| [40]

- | | |
|--|--|
| <p>1. <i>African American/Black</i></p> <p>2. <i>American Indian</i></p> <p>3. <i>Asian/Pacific Islander</i></p> <p>4. <i>Mexican American (Hispanic origin)</i></p> | <p>5. <i>Other Hispanic</i>
(specify): _____</p> <p>6. <i>White (not of Hispanic origin)</i></p> <p>7. <i>Other</i>
(specify): _____</p> |
|--|--|

3. Who has legal custody of this child?..... |_| [41]

- | | |
|--|--|
| <p>1. <i>Mother</i></p> <p>2. <i>Father</i></p> <p>3. <i>Grandparent</i></p> <p>4. <i>Other relative</i></p> | <p>5. <i>State</i></p> <p>6. <i>Other</i>
(specify): _____</p> <p>7. <i>Both mother and father</i></p> |
|--|--|

4. At the time of admission to this program, with whom was the child living?..... |___| [42]
- | | |
|-----------------------------|----------------------------------|
| 1. <i>Mother</i> | 6. <i>Hospital extended care</i> |
| 2. <i>Foster care</i> | 7. <i>Other arrangements</i> |
| 3. <i>Father</i> | (specify): _____ |
| 4. <i>Grandparents</i> | 8. <i>Both mother and father</i> |
| 5. <i>Other relative(s)</i> | |

5. Was the child born while you were in this treatment program?0=No I=Yes [43]

6. Is this child in treatment with you?0=No* I=Yes [44]

***IF CHILD IS NOT IN TREATMENT WITH CLIENT, ASK:**

a. Are you taking necessary steps to have this child in the program with you?.....0=No I=Yes [45]

b. IF "YES", please specify: _____

IF CHILD IS NOT AT FIRST CHOICE WITH CLIENT, STOP HERE

7. Has he or she been in treatment with you before?.....0=No I=Yes [46]

8. Were you living with this child's father during any portion of the 6 months prior to treatment?0=No I=Yes [47]

9. How often has the father been in contact with this child in the last 6 months?..... |___| [48]

- | | |
|---------------------------------|--------------------------------|
| 1. <i>Never</i> | 4. <i>Once a week</i> |
| 2. <i>Once or twice</i> | 5. <i>Several times a week</i> |
| 3. <i>Once or twice a month</i> | 6. <i>Daily</i> |

10. How would you describe this child's relationship with his or her father? |___| [49]

- | | |
|---------------------------|--------------------|
| 1. <i>No relationship</i> | 4. <i>Adequate</i> |
| 2. <i>Distant</i> | 5. <i>Friendly</i> |
| 3. <i>Poor</i> | 6. <i>Close</i> |

11. Do you receive child support from the father?0=No I=Yes 8=NA [50]

12. Does the father use drugs (other than alcohol)?0=No I=Yes 7=Don't know [51]

HEALTH HISTORY

1. Were you using alcohol or drugs (other than nicotine) while pregnant with this child? 0=No 1=Yes* [52]

IF "NO", SKIP TO Q.3

*IF "YES", FOR EACH SEPARATE DRUG USED, ASK:

[HAND "CHILD ANSWER CARD 1" TO RESPONDENT]

a.¹ Using answers from this card, tell me how often you used (drug name) while you were pregnant with this child.
[RECORD RESPONSE IN "DRUG HISTORY CHART"]

b. Did you use alcohol or drugs during the --

1. 1st trimester? 0=No 1=Yes [53]

2. 2nd trimester? 0=No 1=Yes [54]

3. 3rd trimester? 0=No 1=Yes [55]

FREQUENCY OF USE CODES:

0. Never/Not used 3. About 2-3 times per MONTH 6. About 1 time per DAY
 1. Only 1-3 times 4. About 1 time per WEEK 7. About 2-3 times per DAY
 2. About 1 time per MONTH 5. About 2-6 times per WEEK 8. About 4 or more times per DAY

PROBE FOR CLARITY AND CONSISTENCY OF ANSWERS!

DRUG HISTORY CHART

TYPE OF DRUGS (AND EXAMPLES OF EACH)	WHILE PREGNANT	TYPE OF DRUGS (AND EXAMPLES OF EACH)	WHILE PREGNANT
(1) <u>Alcohol</u>	<input type="checkbox"/> [56]	(10) <u>Other Opiates/Opium</u> Morphine/Demerol/ Darvon	<input type="checkbox"/> [65]
(2) <u>Inhalants</u> (glue, spray paint, toluene, liquid paper, etc.).....	<input type="checkbox"/> [57]	(11) <u>Methamphetamine/</u> Speed/Ice/Ecstasy.....	<input type="checkbox"/> [66]
(3) <u>Marijuana/Hashish</u>	<input type="checkbox"/> [58]	(12) <u>Other Amphetamines/</u> Uppers/Diet Pills.....	<input type="checkbox"/> [67]
(4) <u>Hallucinogens/LSD/</u> Psychedelics/PCP/ Mushrooms/Peyote.....	<input type="checkbox"/> [59]	(13) <u>Xanax/Valium/</u> Minor Tranquilizers.....	<input type="checkbox"/> [68]
(5) <u>Crack/Freebase</u>	<input type="checkbox"/> [60]	(14) <u>Barbiturates</u>	<input type="checkbox"/> [69]
(6) <u>Cocaine</u> (by itself).....	<input type="checkbox"/> [61]	(15) <u>Other Sedatives/</u> Hypnotics/ Quaaludes	<input type="checkbox"/> [70]
(7) <u>Heroin and Cocaine</u> (mixed together).....	<input type="checkbox"/> [62]	(16) <u>Other (specify)</u>	<input type="checkbox"/> [71]
(8) <u>Heroin</u> (by itself).....	<input type="checkbox"/> [63]		
(9) <u>Street Methadone</u> (non-prescription)	<input type="checkbox"/> [64]		

2. Did this child test positive for any drugs at birth? 0=No 1=Yes* 2=Not tested [11]

*IF "YES", ASK:

a. What were they?

<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p>TCU CODE</p>			[12-13]		<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p>TCU CODE</p>			[14-15]

3. Did you smoke cigarettes while pregnant with this child? 0=No 1=Yes* [16]

*IF "YES", ASK:

a. During which trimester did you smoke?

1. 1st trimester?	0=No	1=Yes	[17]
2. 2nd trimester?	0=No	1=Yes	[18]
3. 3rd trimester?	0=No	1=Yes	[19]

4. Were there any complications, concerns or health problems at birth? 0=No 1=Yes* [20]

*IF "YES", ASK:

a. What were they?

<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p>TCU CODE</p>			[21-22]		<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p>TCU CODE</p>			[23-24]

5. Did you receive prenatal care when you were pregnant with this child? 0=No 1=Yes [25]

6. Are this child's immunizations current? 0=No 1=Yes 7=Don't know [26]

7. How many months has it been since the last time this child received medical attention (saw a doctor, public health nurse, etc.)?

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 [27-29]
MONTHS

Now I'm going to ask you some questions about your child's current health and behavior.

FOR EACH SEPARATE HEALTH PROBLEM, ASK:

a. Has your child been **diagnosed** with (health problem)?

[FOR EACH HEALTH PROBLEM IDENTIFIED, ASK:]

b. Is this child **receiving treatment**, or scheduled to receive treatment?

Physical Health Disorders	A. HEALTH PROBLEM			*B. RECEIVING TREATMENT			
	NO	YES*		NO	YES	PENDING	
1. Asthma.....	0	1	[30]	0	1	2	[39]
2. Other respiratory condition.....	0	1	[31]	0	1	2	[40]
3. Fetal Alcohol Syndrome.....	0	1	[32]	0	1	2	[41]
4. Fetal Alcohol Effects.....	0	1	[33]	0	1	2	[42]
5. Childhood infectious conditions (e.g., mumps, measles).....	0	1	[34]	0	1	2	[43]
6. Hearing impairment	0	1	[35]	0	1	2	[44]
7. Vision impairment	0	1	[36]	0	1	2	[45]
8. Physical disability (specify): _____	0	1	[37]	0	1	2	[46]
9. Brain injury (specify): _____	0	1	[38]	0	1	2	[47]

10. At admission was the child placed in a neonatal intensive care unit (NICU)?.....0=No 1=Yes* 7=Don't know [48]

*IF "YES":

a. Specify number of days the child spent in the NICU prior to admission?.....	_ _ _	[49-51]
	# DAYS	
b. Special Code	9	[52]

Mental Health Disorders	A. HEALTH PROBLEM			*B. RECEIVING TREATMENT			
	NO	YES*		NO	YES	PENDING	
11. Mental retardation	0	1	[53]	0	1	2	[65]
12. Learning disorder	0	1	[54]	0	1	2	[66]
13. Motor skills disorder.....	0	1	[55]	0	1	2	[67]
14. Communication disorder.....	0	1	[56]	0	1	2	[68]
15. Pervasive developmental disorder	0	1	[57]	0	1	2	[69]
16. Attention Deficit Disorder.....	0	1	[58]	0	1	2	[70]
17. Disruptive behavior disorder	0	1	[59]	0	1	2	[71]
18. Feeding and eating disorders of infancy or early childhood.....	0	1	[60]	0	1	2	[72]
19. Anxiety disorder.....	0	1	[61]	0	1	2	[73]
20. Depression.....	0	1	[62]	0	1	2	[74]
21. Suicidal thoughts.....	0	1	[63]	0	1	2	[75]
22. Post-traumatic stress disorder	0	1	[64]	0	1	2	[76]

23. Special Code [316;03;ID] 9 [11]

	A. HEALTH PROBLEM			*B. RECEIVING TREATMENT			
	NO	YES*		NO	YES	PENDING	
24. Drug use.....	0	1	[12]	0	1	2	[17]
25. Alcohol use.....	0	1	[13]	0	1	2	[18]
26. Sleep problems.....	0	1	[14]	0	1	2	[19]
27. Aggression/anger problems	0	1	[15]	0	1	2	[20]
28. Other (specify): _____	0	1	[16]	0	1	2	[21]

ABUSE HISTORY

1. Has this child ever experienced --	EVER ABUSED			AGE OF FIRST OCCURRENCE	HOW LONG DID ABUSE OCCUR? (MONTHS)
	NO	YES	DON'T KNOW		
a. Physical abuse?.....	0	1	2 [22]	/___/___/ [25-26]	/___/___/ [31-32]
b. Emotional abuse?.....	0	1	2 [23]	/___/___/ [27-28]	/___/___/ [33-34]
c. Sexual abuse?.....	0	1	2 [24]	/___/___/ [29-30]	/___/___/ [35-36]
				AGE	# MONTHS

*Specify whether abuse was reported, when and to whom: _____

JUVENILE JUSTICE SYSTEM (JJS) INVOLVEMENT

1. Has the child been involved with the juvenile justice system?.....0=No 1=Yes* 7=Don't know [37]

*IF "YES" ASK:

<p>a. Has the child been incarcerated in a juvenile justice facility?.....0=No 1=Yes* 7=Don't know [38]</p> <p>IF "YES":</p> <p>1. How many times has the child been incarcerated in a juvenile justice facility?..... # TIMES</p> <p>2. For how long?..... # MONTHS</p>

EDUCATIONAL STATUS

1. Is this child between 0 and 5 years of age?.....0=No 1=Yes* [39]

IF "NO", SKIP TO Q.2

*IF "YES" AND CHILD IS NOT IN KINDERGARTEN, ASK:

<p>a. What type of day care arrangements did you have for your child during the 6 months prior to treatment?..... __ [40]</p> <table> <tr> <td>1. Mother</td> <td>5. Non-relative family day home</td> </tr> <tr> <td>2. Spouse/partner</td> <td>6. Child care center</td> </tr> <tr> <td>3. Adult relative</td> <td>7. No one/child old enough to care for self</td> </tr> <tr> <td>4. Sibling/child relative under 18</td> <td></td> </tr> </table> <p>b. Approximately how many hours per week did your child spend in that setting?..... __ __ [41-42] # HOURS</p> <p>c. How long (months) did your child go to this place? __ __ [43-44] # MONTHS</p> <p>d. How satisfied were you with the quality of care your child received there? __ [45]</p> <table> <tr> <td>1. very dissatisfied</td> <td>4. satisfied</td> </tr> <tr> <td>2. dissatisfied</td> <td>5. very satisfied</td> </tr> <tr> <td>3. neither dissatisfied nor satisfied</td> <td></td> </tr> </table> <p>e. Altogether, how many times have you changed your child care arrangements for this child..... __ __ [46-47] # TIMES</p>	1. Mother	5. Non-relative family day home	2. Spouse/partner	6. Child care center	3. Adult relative	7. No one/child old enough to care for self	4. Sibling/child relative under 18		1. very dissatisfied	4. satisfied	2. dissatisfied	5. very satisfied	3. neither dissatisfied nor satisfied	
1. Mother	5. Non-relative family day home													
2. Spouse/partner	6. Child care center													
3. Adult relative	7. No one/child old enough to care for self													
4. Sibling/child relative under 18														
1. very dissatisfied	4. satisfied													
2. dissatisfied	5. very satisfied													
3. neither dissatisfied nor satisfied														



2. Is the child of school age (5 years or older)?.....0=No 1=Yes* [48]

IF "NO", SKIP TO NEXT SECTION

***IF "YES" ASK:**

a. When you entered this treatment program, was this child enrolled in school?	0=No*	1=Yes	[49]
*IF NOT ENROLLED, SPECIFY REASON _____			
b. In what grade is the child?.....			[50]
		GRADE	
0. Kindergarten	3. 3rd Grade	6. 6th Grade	
1. 1st Grade	4. 4th Grade	7. 7th Grade	
2. 2nd Grade	5. 5th Grade	8. 8th Grade	
		9. Not enrolled	
c. Does she/he score at grade level or higher on standardized tests?	0=No*	1=Yes*	7=Don't know [51]
*SPECIFY TEST, IF KNOWN _____			
d. Did she/he successfully complete the most recent academic year?	0=No	1=Yes	7=Don't know [52]
e. Does she/he require special attention in school?.....	0=No	1=Yes	7=Don't know [53]
f. Who cared for this child after school?			[54]
1. Mother	5. Non-relative family day home		
2. Spouse/partner	6. Child care center		
3. Adult relative	7. No one/child old enough to care for self		
4. Sibling/child relative under 18			
g. Approximately how many hours per week did the child spend in that setting?			[55-57]
		# HOURS	



PARENTAL DISCIPLINE

1. How often do you use each of the following methods to discipline (name of child)?
 [HAND "CHILD ANSWER CARD 2" TO RESPONDENT]

	NEVER	ONCE OR TWICE A YEAR	ONCE A MONTH	ONCE A WEEK	SEVERAL TIMES A WEEK	ONCE A DAY	SEVERAL TIMES A DAY	
1. Explain, provide a reason for, or teach what is expected.....	0	1	2	3	4	5	6	[58]
2. Verbally prohibit child from misbehaving.....	0	1	2	3	4	5	6	[59]
3. Use physical punishment.....	0	1	2	3	4	5	6	[60]
4. Use physical restraint.....	0	1	2	3	4	5	6	[61]
5. Isolate child.....	0	1	2	3	4	5	6	[62]
6. Remove privileges	0	1	2	3	4	5	6	[63]
7. Threaten punishment.....	0	1	2	3	4	5	6	[64]
8. Ignore child's behavior.....	0	1	2	3	4	5	6	[65]

2. Which of the above methods is most effective for (name of child)?..... |___| [66]

3. Some parents believe that spanking a child is a necessary or important way of training a child not to misbehave; other parents believe spanking should never be used in bringing up children. How do you feel about spanking? |___| [67]

1. Believe that spanking should never be used
2. Believe that spanking should rarely be used
3. Believe that spanking should be used in moderation
4. Believe that spanking should be used as needed

TCU/FC CHILD INTAKE TRAILER

[316;04;ID]

1. Which is the major source of support for your child?..... |__| [11]

1. Financial assistance from spouse/domestic partner
2. Child support from former spouse/father of child(ren)
3. Financial assistance from family
4. Financial assistance from friends
5. Public assistance (SSI, WIC, AFC, ECI)
6. Your (respondent's) earned income
7. Other (specify) _____

2. During the 2 years prior to admission, has your child been homeless (living on streets, in homeless shelter, sleeping in empty buildings, etc.)?.....0=No I=Yes* 7=Unknown [12]

*IF "YES", ASK:

a. For how many months was your child homeless?..... __ __ [13-14] # MONTHS

3. Has your child been removed from your care by Child Protective Services during the past 6 months?0=No I=Yes* 7=Unknown [15]

*IF "YES", ASK:

a. How many times has your child been removed from your care during that time? __ __ [16-17] # TIMES
b. For how many months has your child been removed from your care?..... __ __ [18-19] # MONTHS

4. At birth, did your child have a condition that required placement in a neonatal intensive care unit (NICU)?0=No I=Yes* [20]

*IF "YES", ASK:

a. How many days did your child spend in the NICU?..... __ __ __ [21-23] # DAYS
b. Was the condition related to drug/alcohol exposure in utero (while you were pregnant)?0=No I=Yes 7=Unknown [24]

5. During the past 12 months, has your child received treatment for health or medical problems in an emergency room? 0=No I=Yes* [25]

*IF "YES", ASK:

a. How many times has your child been treated? __ __ [26-27] # TIMES
--

6. Now I'm going to ask you some questions about your child's current health.

FOR EACH SEPARATE HEALTH PROBLEM, ASK:

- a. Has your child been **diagnosed** with (health problem)?
 [FOR EACH HEALTH PROBLEM IDENTIFIED, ASK:]
- b. Is this child **receiving treatment**, or scheduled to receive treatment?

Physical Health Disorders	A. HEALTH PROBLEM			*B. RECEIVING TREATMENT			
	NO	YES*		NO	YES	PENDING	
1. Tuberculosis.....	0	1	[28]	0	1	2	[31]
2. Physical trauma (specify): _____	0	1	[29]	0	1	2	[32]
3. Other physical health problem or illness (if HIV+/AIDS, record as "immune disorder") (specify): _____	0	1	[30]	0	1	2	[33]

7. Has your child ever used tobacco products?0=No 1=Yes 7=Unknown [34]

8. Has your child ever consumed alcohol
(beer, wine, hard liquor)?.....0=No 1=Yes 7=Unknown [35]

9. Has your child ever used other drugs
(marijuana, hallucinogens, amphetamines,
barbiturates, inhalants)?.....0=No 1=Yes 7=Unknown [36]

10. Has your child ever experienced --

	NO	YES	UNKNOWN	
a. Any form of sexual abuse by a relative, including incest.....	0	1	7	[37]
b. Sexual abuse by a non-relative	0	1	7	[38]
c. Emotional neglect	0	1	7	[39]
d. Being a witness to violence	0	1	7	[40]

11. Does your child require special education services
in school?0=No 1=Yes 7=Don't know [41]

End of This Interview--Thanks!