MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES

NURSING INTAKE FORM

Name: _____	**Admission Date:** _____ **Completion Date:** _____
DOB: _____ **Commitment Number:** _____	**County:** _____
Social Security Number: _____	**Previous Commitment(s):** Yes ☐ No ☐
	Date of Last Parole: _____

Male ☐ **Female** ☐ **Ethnicity:** _____ **Religion:** _____

Emergency Notification:

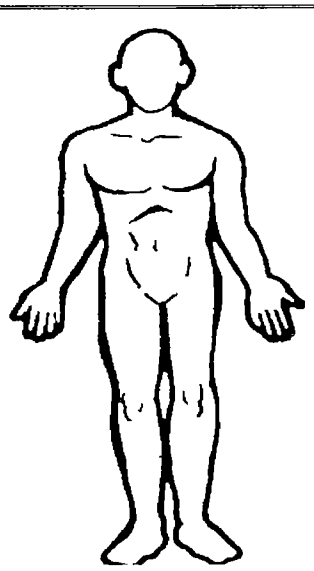
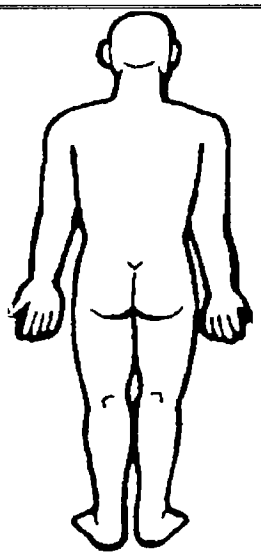
Name: _____ Relationship: _____ Phone (____)_____ Other (____)_____

Address: _____ City _____ State _____ Zip Code _____

Vital Signs:

Temp: _____ O2 sat_____ Pulse: _____ Respirations: _____ BP: _____/_____

Physical Description: Hair Color: _____ Eye Color: _____ Height: _____ Weight: _____

ANATOMICAL FRONT	ANATOMICAL BACK	ANATOMICAL NOTATION
		

Graphic: **A**=Abrasion, **B**=Birthmark, **B2**=Burn, **B3**=Bruise, **C**=Cut, **K**=Keloid, **L**=Lesions, **N**=Needle Marks, **R**=Rash, **S**=Scar, **S2**=Scratches, **S3**=Sutures, **T**=Tattoo

Food and/or Drug Allergies: Yes ☐ NO ☐ Don't Know ☐

Allergies:			
Symptoms:			

Current Medications: Yes ☐ No ☐ (Drug, Dose, Frequency, Duration, Reason & Last Dose): Medications brought with Youth: Yes ☐ No ☐

Dental Screening: Last Dental Visit: _____ Visual Screening Completed: Yes ☐ No ☐ Current Complaints: Yes ☐ No ☐

Nurse Signature: _____ Date: _____ Time: _____ Physician's Initials _____

Name: _____

DOB: _____

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Nursing Intake Form

Hospitalizations/Surgeries: Yes ☐ NO ☐ Don't Know ☐ (Reason, Hospital and/or Surgery Date)

Health History: (Check the Problems that Apply with a **P** for Past, **C** for Current or **NA** for Not Applicable)

No	Problem List	P/C/NA
1	Anemia/Blood	
2	Asthma/Respiratory Disorders	
3	Bedwetting/UTI/ Kidney Problems	
4	Body Deformities/ Physical Disability	
5	Cancer	
6	Chicken Pox	
7	Constipation/Diarrhea/Colitis/Ulcers	
8	Diabetes	
9	ENT Problems (Hearing Loss)	
10	Eye Problems (Vision Loss)	
11	Fainting/Dizziness	

No	Problem List	P/C/NA
12	Fractures	
13	Headaches (Frequent/Severe)	
14	Head Injuries (Concussion)	
15	Heart Condition/Murmur	
16	Hemophilia	
17	Hemorrhoids	
18	Hernia	
19	Hypertension	
20	Joint Discomfort/Ease of Movement	
21	Arthritis	
22	Liver Disease/ Hepatitis	

No	Problem List	P/C/NA
23	Scoliosis	
24	Seizure Disorder	
25	Sickle Cell (Trait/Anemia)	
26	Skin Conditions/Acne	
27	HIV/AIDS	
28	Sexually Transmitted Diseases	
29	Thyroid Disorder	
30	Tuberculosis (Disease/Infection)	
31	Other	
32	Sexual Intercourse: Yes ☐ _____ No ☐ If Yes: Protected ☐ Unprotected ☐	

Comments (by number):

Mental Health Screening:

Yes ☐ No ☐ History of Psychiatric Disorder — Diagnosis: _____
Yes ☐ No ☐ History of inpatient mental health treatment — Where: _____
Yes ☐ No ☐ Current mental health complaint/treatment — **For:** _____
Yes ☐ No ☐ History of outpatient mental health treatment — Where: _____
Yes ☐ No ☐ History/Current thoughts of Suicide — Comment: _____

Substance Use Screening: Use of alcohol and other drugs, including type, mode, amounts, frequency and date last time used.

Family History: (Parent, grandparent, sibling had any of the following)

Condition		Relative
Asthma	Yes ☐ No ☐ Don't Know ☐	
Bleeding Disorder	Yes ☐ No ☐ Don't Know ☐	
Cancer	Yes ☐ No ☐ Don't Know ☐	
Diabetes	Yes ☐ No ☐ Don't Know ☐	
Heart Trouble	Yes ☐ No ☐ Don't Know ☐	
High Blood Pressure	Yes ☐ No ☐ Don't Know ☐	

Condition		Relative
Liver Disease	Yes ☐ No ☐ Don't Know ☐	
Psychiatric Disorder	Yes ☐ No ☐ Don't Know ☐	
Seizures	Yes ☐ No ☐ Don't Know ☐	
Sickle Cell Anemia	Yes ☐ No ☐ Don't Know ☐	
Stroke	Yes ☐ No ☐ Don't Know ☐	
Tuberculosis	Yes ☐ No ☐ Don't Know ☐	

Nurse Signature: _____ Physician's Initials _____

Name: _____
DOB: _____

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Nursing Intake Assessment Form

General Observation and Assessment:

1. Visible signs of trauma, abuse or illness requiring immediate medical intervention: Yes ☐ No ☐

If yes, describe:

2. Presence of fever, swollen lymph glands, jaundice, rash, or any other signs of infection or parasitic infestation: Yes ☐ No ☐

If yes, describe:

3. **Behavior** (verbal interaction, mental status, appearance, conduct, tremor, and sweating) **and/or General Comments**:

4.

Assessment	**Documentation**
Level of Consciousness (LOC)	
Breath Sounds	
Heart Sounds	
Abdomen	
Skin Turgor	
Peripheral Pulse	
Range of Motion (ROM)	

5. **Additional Comments**:

- **Youth instructed on how to access health care Services; Signed Welcome Letter**: Yes ☐ No ☐
- **Youth cleared for general population**: Yes ☐ NO ☐
- **Youth cleared for general population with medical, dental, mental health referral made**: Yes ☐ NO ☐ N/A ☐
- **Youth Referral for emergency medical and/or mental health treatment**: Yes ☐ NO ☐ N/A ☐

Nurse Signature: _____ Date: _____ Physician's Initials _____

Name: _____

DOB: _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
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Nursing Intake Form

FEMALE HEALTH HISTORY

1. Age at onset of menses: _____ Date of last menses: _____
   - Interval between menses: _____
   - Duration of menses: _____
   - Quantity of flow: Heavy ☐ Normal ☐ Light ☐
   - Do you have pain with menses? Yes ☐ No ☐ If yes, is pain: Low ☐ Moderate ☐ High ☐
   - Is your menses regular? Yes ☐ No ☐
     If no, explain: _____
2. Have you had any unusual vaginal discharge? Yes ☐ No ☐
   If yes, when? _____
3. Have you been treated for any female disorders? Yes ☐ No ☐
   If yes, explain: _____
4. Are you or have you recently been on any birth control? Yes ☐ No ☐
   If yes, what type _____
5. Date of last intercourse: _____ Protected: Yes ☐ No ☐ Type Birth Control : _____

6. Do you think you might be, or are you, pregnant? Yes ☐ No ☐
   If yes, your expected date of delivery: _____
   - Number of past pregnancies: (**G**) _____
   - Any problems with pregnancies: Yes ☐ No ☐
     If yes, explain: _____

     _____

   Number of Term (**T**) {37-42 weeks}deliveries _____; premature (**P**) {25-36 weeks} _____;

   (**A**)abortions {planned or natural loss up to 25 weeks} _____; (**L**) Living children_____

   - Are you currently receiving pre-natal care? Yes ☐ No ☐
     If yes, where? _____

7. Do you do monthly self-breast exams? Yes ☐ No ☐
   - Do you have, or have you had, any problems with your breasts? Yes ☐ No ☐
     If yes, explain: _____

     _____

Comments:

Nurse Signature: _____ Date: _____ Physician's Initials _____