Client Initials: _____ DOB: _____ Age: _____

Pilot Program **Problematic Sexual Behavior** **INTAKE SHEET**

DATE: **TIME:**	**DATE:** **TIME:**
PERSON CALLING:	**PERSON CALLING:**
AGENCY/RELATIONSHIP:	**AGENCY/RELATIONSHIP:**
PHONE NUMBER:	**PHONE NUMBER:**

NAME OF CHILD: _____ **AGE:** _____**DOB:** _____

REFERRED BY: _____

First Step Evaluation(s) occurred on: _____

	YES	**NO**
INSURANCE Type (if known): _____	☐	☐
CAREGIVER INVOLVEMENT	☐	☐

Caregiver name(s): _____ _____

_____ _____

Phone numbers: _____ _____

SAFETY PLAN NOTES _____

NATURE OF REPORT (check all that apply):

- ☐ Sexual behaviors with other children
- ☐ Inappropriate use of technology
- ☐ Aggression, threat, force, and or/use of coercion
- ☐ Exclusive sexual Behaviors (e.g. excessive masturbation)
- ☐ Other (Please describe): _____

TO ASSESS FOR PSB, MARK ALL THAT APPLY:

Frequency	Developmental Considerations	Harm
☐ High frequency	☐ Occurs between children of significantly divergent ages/developmental abilities	☐ Intrusive behaviors
☐ Excludes normal childhood activities	☐ Behaviors are longer in duration than developmentally expected	☐ Includes force, intimidation, and/or coercion
☐ Unresponsive (i.e., does not decrease) to typical parenting strategies	☐ Behavior interferes with social development	☐ Elicits fear & anxiety in other children

Client Initials: _____ DOB: _____ Age: _____

ADDITIONAL NOTES OR CONCERNS THAT MAY INFLUENCE PSB (e.g., DD/ID; mental health diagnoses):

_____

_____

_____

COMPLETED SCREENS AND ASSESSMENTS:

Screens	
☐ Child and Adolescent Trauma Screen (CATS – child self-report) Date: _____	☐ Child and Adolescent Trauma Screen (CATS – caregiver report) Date: _____

Assessments (Clinical Decision)	
☐ Child Sexual Behavior Inventory (CSBI) Date: _____	☐ Trauma Symptom Checklist for Children (TSCC) Date: _____
☐ Trauma Symptom Checklist for Young Children (TSCYC) Date: _____	☐ Caregiver Intake Assessment Date: _____
☐ Child Intake Assessment Date: _____	
☐ Other relevant screens and assessments: Date: _____ _____	

SYSTEMS INVOLVED **YES** **NO**

1. YOUTH COURT: ☐ ☐
   Name _____ Phone: _____
2. CHILD & FAMILY SERVICES: ☐ ☐
   Name: _____ Phone: _____
3. LAW ENFORCEMENT: ☐ ☐
   County or City: _____ Name: _____
4. COUNTY ATTORNEY'S OFFICE: ☐ ☐
   Name: _____ Phone: _____
5. MENTAL HEALTH AGENCIES: _____ ☐ ☐
   Names: _____
6. OTHER AGENCY INVOLVEMENT: _____ ☐ ☐

Criteria (must meet all)

- Age 14 or less **YES** ☐ **NO** ☐
- Problematic sexual behavior **YES** ☐ **NO** ☐
- History of trauma **YES** ☐ **NO** ☐
- Caregiver involvement **YES** ☐ **NO** ☐

Referral made based on met criteria: **YES** ☐ **NO** ☐

If criteria is not met, communicate reason to MDT ☐

Clinician _____