

South Carolina Department of Social Services  
**CHILD FACTORS CHECKLIST FOR ADOPTION**

*Note: SCDSS cannot and will not deny prospective foster/adoptive parents the opportunity to foster/adopt on the basis of race, color or national origin; nor delay or deny the placement of children on the basis of race, color or national origin.*

Date Completed or Updated: \_\_\_\_\_

Child's Name: \_\_\_\_\_

CWS Adoption Case Manager: \_\_\_\_\_

CWS Adoption Supervisor: \_\_\_\_\_

Region: \_\_\_\_\_

**Instructions: Type "X" in each box that applies**

	Yes	No
<b>Gender/Sex of child</b>		
Female	<input type="checkbox"/>	<input type="checkbox"/>
Male	<input type="checkbox"/>	<input type="checkbox"/>
Non-binary/Transgender	<input type="checkbox"/>	<input type="checkbox"/>
<b>Orientation</b>		
Identifies as LGBTQ+	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No
<b>Birth History</b>		
Low birth weight or premature	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Alcohol Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Alcohol Effects	<input type="checkbox"/>	<input type="checkbox"/>
Positive toxicology screen at birth (one or more of the following: Cocaine, Amphetamines, Heroin, Morphine, Phencyclidine (PCP), Alcohol, Benzodiazepines, Hydromorphone, Marijuana, Propoxyphene, Methadone, Codeine)	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal Drug Exposure (one or more of the following: Cocaine, Amphetamines, Heroin, Morphine, Phencyclidine (PCP), Alcohol, Benzodiazepines, Hydromorphone, Marijuana, Propoxyphene, Methadone, Codeine)	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction at Birth (heroin, methadone, morphine, or other)	<input type="checkbox"/>	<input type="checkbox"/>
Shaken Baby Syndrome	<input type="checkbox"/>	<input type="checkbox"/>

Please use the following guidelines for determining the **level of disability** you are open to accepting when filling out the following form.

**Developmental disability:**

**Mild**  
Characteristics of individuals with mild developmental disability include, for example: has an IQ range of 50–75 will eventually be able to live independently, hold a job, and manage his or her life with some guidance.

**Moderate**  
Characteristics of individuals with moderate developmental disability include, for example: has an IQ range of 25–50 who may achieve partial self-support in a sheltered work place but will always need supervision and to live in a group home or family setting.

**Severe**

Characteristics of individuals with severe developmental disability include, for example: has an IQ of less than 25 who may be able to partially contribute to self-care but will always need ongoing supervision and help with daily routines.

<b>Developmental</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failure to Thrive (organic or environmental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deaf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visually Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the following guidelines for determining the **level of disability** you are open to accepting when filling out the following form.

**Physical disability:**

**Mild**  
 Characteristics of individuals with mild physical disability include, for example: requires no equipment for daily functioning; requires average or slightly above average medical care; can perform basic life-management functions appropriate for child's age and development; can use mainstream methods of transportation and communication; has a condition that is totally managed by medication; has a condition that is correctable or improves on its own with time; is delayed in physical development but has a prognosis of catching up.

**Moderate**  
 Characteristics of individuals with moderate physical disability include, for example: requires equipment but not life-support equipment, has a relatively stable condition (while not correctable, the condition is not progressive or degenerative, requires moderate home modifications; may require corrective surgery; requires up to weekly medical appointments; can perform basic life-management functions appropriate for child's age and development (feeding, dressing, toileting) with some assistance; may require some assistance with transportation and communication.

**Severe**  
 Characteristics of individuals with severe physical disability include, for example: requires life-support equipment; has a progressive, degenerative, or terminal illness; requires significant home modifications; requires repeated or frequent hospitalizations or surgeries; requires two or more medical appointments per week; requires a parent or aide to perform basic life-management functions (feeding, dressing, toileting, etc.); always requires special adaptations for transportation and/or communication.

	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
<b>Physical Conditions</b>				
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma: No treatment required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma: Treatment required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic liver disease (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Juvenile Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Cancer: In Remission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: Requires treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/palate (may require surgery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/palate (already corrected)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems (may include tooth decay, missing teeth, crowded or misaligned teeth, overbite, under bite)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Insulin-dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Non—Insulin Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Down’s Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Defect/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history of Huntington’s Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney issues/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lead Poisoning (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited verbal	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Macrocephalic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microcephalic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medically fragile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missing limb(s) (may require prosthesis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-verbal	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Orthodontic work required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous Pregnancy(ies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder (other than Epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(History of sexually transmitted disease (syphilis, gonorrhea, herpes simplex II, chlamydia, other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently has sexually transmitted disease (syphilis, gonorrhea, herpes simplex II, chlamydia, other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injury (TBI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair Dependent	Yes <input type="checkbox"/> No <input type="checkbox"/>			

	Yes	No
<b>Medication</b>		
Requires daily medication for one or more physical conditions	<input type="checkbox"/>	<input type="checkbox"/>
Requires daily medication for one or more mental health conditions	<input type="checkbox"/>	<input type="checkbox"/>
<b>Requires Specialized Care</b>		
Non-Ambulatory	<input type="checkbox"/>	<input type="checkbox"/>
Physically Disabled	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy: Short-term	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy: Long-term	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy: Short-term	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy: Long-term	<input type="checkbox"/>	<input type="checkbox"/>
Requires Intermittent Medical Treatment & Evaluation	<input type="checkbox"/>	<input type="checkbox"/>
<b>Requires Specialized In-Home Care</b>		
Tracheotomy	<input type="checkbox"/>	<input type="checkbox"/>
Naso-gastric tube	<input type="checkbox"/>	<input type="checkbox"/>
Gastric tube	<input type="checkbox"/>	<input type="checkbox"/>
Apnea monitor	<input type="checkbox"/>	<input type="checkbox"/>
Nebulizer	<input type="checkbox"/>	<input type="checkbox"/>
Requires Lifelong Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Requires Lifelong Supervision/Care	<input type="checkbox"/>	<input type="checkbox"/>
<b>Limited Life Expectancy</b>		
Terminally Ill (life expectancy less than 1 year)	<input type="checkbox"/>	<input type="checkbox"/>
Limited life expectancy due to chronic illness or disabling condition	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sleeping Problems</b>		
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Afraid of the dark and/or sleeping in the dark	<input type="checkbox"/>	<input type="checkbox"/>
Sleep walking	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting (Enuresis – over 5 years of age, at night)	<input type="checkbox"/>	<input type="checkbox"/>
Soils bed at night (Encopresis)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dietary or Eating Problems</b>		
Requires special diet	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia (may require treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Pica	<input type="checkbox"/>	<input type="checkbox"/>
Hoarding food	<input type="checkbox"/>	<input type="checkbox"/>
Overeating	<input type="checkbox"/>	<input type="checkbox"/>

Please use the following guidelines for determining the **level of disability** you are open to accepting when filling out the following form.

**Emotional disability:**

**Mild**  
 Characteristics of individuals with mild emotional disability include, for example: functioning well in school, at home, and with peers. If symptoms are present, they are transient and may be a result of developmental stage or expected reaction to external stressors (such as anxiety, sadness, or behavioral difficulty related to introduction to new situations, losses, or changes in the child's environment); able to communicate needs and understand rules as well as consequences of behavior (depends on developmental

stage); may use substances; does not require medication or therapeutic mediation at this time but may benefit from counseling in dealing with emotions and behaviors that may be causing difficulty.

**Moderate**

Characteristics of individuals with moderate emotional disability include, for example: symptoms are present but child is able to function with some assistance in school, at home, and with peers; displays anxiety, depression, behavioral problems that can be mediated by medication, behavior therapy, or counseling as needed (these behavioral problems can include: occasional panic attacks or severe anxiety that is not precipitated by external stressors; sexually inappropriate behavior but not sexual abuse of others; episodic use of substances; some conflicts with teachers, peers, or others in authority; fighting; occasional theft or lying; depressed mood without suicidal ideation; encopresis or enuresis; poor judgement or impulse control; hard-to-manage behaviors that are not destructive or violent; isolating behavior; difficulty maintaining friendships; difficulty in communicating needs in an appropriate fashion, sometimes losing sight of consequences of behavior (depends on developmental stage).

**Severe**

Characteristics of individuals with severe emotional disability include, for example: serious impairment in social and academic functioning; occasional to persistent danger of severely hurting self or others; recurrent violence that appears un-precipitated; a pattern of cruelty to animals; fire-setting behaviors; inability to maintain personal hygiene; sexual abuse of others; gross impairment in ability to communicate (largely incoherent); inability to see consequences of actions or show empathy for others; significant destruction of property; gross impairment in reality testing, judgement, and thinking; persistent use of substances; self-mutilating behavior; presence of hallucinations or delusions (that are not related to substance abuse or organic difficulty); may require repeated psychiatric hospitalizations or 24-hour monitoring; requires medication and consistent psychiatric assistance; may have poor prognosis for adult level of functioning.

	None	Mild	Moderate	Severe
<b>Emotional/Mental Health</b>				
Adjustment disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder—Generalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attachment Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder (ADD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism or Asperger’s Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bi-polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires or is currently in counseling/therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refuses counseling/therapy or medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive Mood Dysregulation Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermittent Explosive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive Compulsive Disorder (OCD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Defiant Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous psychiatric hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reactive Attachment Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or other psychotic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Separation anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the following guidelines for determining the **level of disability** you are open to accepting when filling out the following form.

**Learning disability:**

**Mild**  
 Characteristics of individuals with mild learning disability, for example: functioning well in school and at home, can be mainstreamed with help from a resource room or tutoring.

**Moderate**  
 Characteristics of individuals with moderate learning disability, for example: consistent difficulty in functioning in school and possibly at home, may need long-term special education.

**Severe**  
 Characteristics of individuals with severe learning disability, for example: significant and pervasive difficulty in functioning in school and at home, may have learning disabilities that cause permanent difficulty in academics, social and emotional functioning, or occupational functioning.

	Yes	No
<b>Education/Preschool Child</b>		
Requires early intervention services for developmental delay	<input type="checkbox"/>	<input type="checkbox"/>
Attends Head Start	<input type="checkbox"/>	<input type="checkbox"/>
Attends Therapeutic Head Start	<input type="checkbox"/>	<input type="checkbox"/>
<b>Education/School Age Child</b>		
Achieves below grade level in regular classes	<input type="checkbox"/>	<input type="checkbox"/>
Child struggles with school	<input type="checkbox"/>	<input type="checkbox"/>
Child has repeated grade	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Functioning: Below Average	<input type="checkbox"/>	<input type="checkbox"/>
Has behavior problems in school: Occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Has behavior problems in school: Frequently	<input type="checkbox"/>	<input type="checkbox"/>
Academic Problems: Occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Academic Problems: Frequently	<input type="checkbox"/>	<input type="checkbox"/>
Needs tutoring in one or more subjects	<input type="checkbox"/>	<input type="checkbox"/>
Child may require educational testing	<input type="checkbox"/>	<input type="checkbox"/>
Truancy	<input type="checkbox"/>	<input type="checkbox"/>
Suspension(s)	<input type="checkbox"/>	<input type="checkbox"/>
Expulsion(s)	<input type="checkbox"/>	<input type="checkbox"/>
Academically behind due to poor attendance	<input type="checkbox"/>	<input type="checkbox"/>
Child is involved in after school activities (sports, dance, clubs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Child is in alternative school for emotional, developmental, psychological, or behavior problems	<input type="checkbox"/>	<input type="checkbox"/>
Has IEP (Individualized Education Plan)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Overall Learning Disabilities</b>		
Central Auditory Processing Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Articulation Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>
Expressive Learning Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Motor Skills Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Non-Specific Learning Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Receptive Language Disability	<input type="checkbox"/>	<input type="checkbox"/>

Please use the following guidelines for determining the **level of disability** you are open to accepting when filling out the following form.

**Behavioral issues:**

**Mild**

Characteristics of individuals with mild behavioral disability include, for example: re-directable; behavior will likely change with therapy; amount of adult attention is age appropriate; can be left unsupervised (at age-appropriate level).

**Moderate**

Characteristics of individuals with moderate behavioral disability include, for example: displays acting-out behaviors, but not destructive or hurtful; has risky behaviors without the understanding of consequences; will benefit from therapy but likely will not show immediate progress.

**Severe**

Characteristics of individuals with severe behavioral disability include, for example: needs line-of-sight supervision; likely has one-on-one support or alternative school setting; has been physically and verbally aggressive toward adults and peers; has tendency to be a danger to self or others; would benefit from therapy, but it may not change behaviors; may be in detention or have juvenile justice involvement.

	None	Mild	Moderate	Severe
<b>Behaviors &amp; Characteristics</b>				
Head banging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rocking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to reject father figures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to reject mother figures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tends to form superficial relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in attaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not affectionate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manipulative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Defiant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty making friends and relating with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soils him/herself during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temper Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor social skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child can be disruptive in social settings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty accepting and obeying rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequently starts physical fights with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive toward other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive toward adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gang involvement (past)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gang involvement (present)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-abusive thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-harming behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Substance Use &amp; Abuse</b>	<b>None</b>	<b>Occasional Use</b>	<b>Frequent Use</b>
Smokes cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chews tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires or has completed treatment program for substance abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

	<b>Yes</b>	<b>No</b>
<b>Other Behaviors</b>		
Runaway: Occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Runaway: Frequently	<input type="checkbox"/>	<input type="checkbox"/>
Runaway: Past	<input type="checkbox"/>	<input type="checkbox"/>
Breaks curfew	<input type="checkbox"/>	<input type="checkbox"/>
Abusive to animals: Occasionally	<input type="checkbox"/>	<input type="checkbox"/>
Abusive to animals: Frequently	<input type="checkbox"/>	<input type="checkbox"/>
Abusive to animals: Past	<input type="checkbox"/>	<input type="checkbox"/>
Destructive of: Clothing, toys	<input type="checkbox"/>	<input type="checkbox"/>
Destructive of: Household property	<input type="checkbox"/>	<input type="checkbox"/>
Destructive of: School or other public property	<input type="checkbox"/>	<input type="checkbox"/>
Uses foul language	<input type="checkbox"/>	<input type="checkbox"/>
Child obsessed with guns, knives, explosives, or other destructive devices or themes	<input type="checkbox"/>	<input type="checkbox"/>
Currently plays with matches/lighters	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Yes</b>	<b>No</b>
<b>Sexual Behavior</b>		
Sexually active (past)	<input type="checkbox"/>	<input type="checkbox"/>
Sexually active (present)	<input type="checkbox"/>	<input type="checkbox"/>
History of inappropriate sexual behavior	<input type="checkbox"/>	<input type="checkbox"/>
Child involved in prostitution	<input type="checkbox"/>	<input type="checkbox"/>
Known sexual perpetrator	<input type="checkbox"/>	<input type="checkbox"/>
Sexual offender (juvenile adjudication)	<input type="checkbox"/>	<input type="checkbox"/>
Sexual perpetrator who has successfully completed treatment	<input type="checkbox"/>	<input type="checkbox"/>
Child at risk for offending sexual behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Child has initiated sexual behavior toward other adults	<input type="checkbox"/>	<input type="checkbox"/>
Child has initiated sexual behavior toward other children	<input type="checkbox"/>	<input type="checkbox"/>
Sexually acting out behavior (may include public masturbation or exposing of genitals, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Sexually provocative with peers	<input type="checkbox"/>	<input type="checkbox"/>
Sexually provocative with adults	<input type="checkbox"/>	<input type="checkbox"/>

	<b>None</b>	<b>Current charges</b>	<b>Past conviction</b>
<b>Juvenile Court Involvement</b>			
Previously incarcerated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently incarcerated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Registered sex offender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Current charges	Past conviction
Court order for restitution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Court order for child support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is on probation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child is on parole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has participated in court diversion program(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has had serious on-going involvement with Juvenile Court for delinquent or assaulting behaviors in the past 2 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggravated murder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Murder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involuntary manslaughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felonious assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggravated assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual battery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross sexual imposition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conspiracy to commit aggravated murder or murder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use or possession of a firearm or body armor in an offense that would be considered a felony if committed by an adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breaking curfew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crime using a weapon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other delinquency adjudication(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
<b>Family History</b>		
Child has strong ties to birth family	<input type="checkbox"/>	<input type="checkbox"/>
Child needs continued contact with parents	<input type="checkbox"/>	<input type="checkbox"/>
Child needs continued contact with siblings	<input type="checkbox"/>	<input type="checkbox"/>
Child needs continued contact with other relatives	<input type="checkbox"/>	<input type="checkbox"/>
Child needs continued contact with foster family due to strong ties	<input type="checkbox"/>	<input type="checkbox"/>
Child needs continued contact to a non-related significant other due to strong ties	<input type="checkbox"/>	<input type="checkbox"/>
Sexually abused: indirect	<input type="checkbox"/>	<input type="checkbox"/>
Sexually abused: direct	<input type="checkbox"/>	<input type="checkbox"/>
Physically abused	<input type="checkbox"/>	<input type="checkbox"/>
Psychologically or emotionally abused	<input type="checkbox"/>	<input type="checkbox"/>
Child victim of physical neglect	<input type="checkbox"/>	<input type="checkbox"/>
Child victim of emotional neglect	<input type="checkbox"/>	<input type="checkbox"/>
Child exposed to domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
Child conceived as a result of rape	<input type="checkbox"/>	<input type="checkbox"/>
Child conceived as a result of prostitution	<input type="checkbox"/>	<input type="checkbox"/>
Child conceived as a result of incest	<input type="checkbox"/>	<input type="checkbox"/>
Incest family history	<input type="checkbox"/>	<input type="checkbox"/>
Criminal history	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
<b>History of one or both parents</b>		
Child exposed to mental illness by other than family member	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
Family history of domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
Child exposed to domestic violence by other than family member	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have drug addiction	<input type="checkbox"/>	<input type="checkbox"/>
Mother used alcohol during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Mother used drugs during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Agency has no information about the birth father	<input type="checkbox"/>	<input type="checkbox"/>
Agency has no information about either parent (i.e. 'safe haven' baby)	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have criminal record	<input type="checkbox"/>	<input type="checkbox"/>
One or both parents have diagnosed mental illness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bi-polar disorder	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Borderline personality disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other personality disorder	<input type="checkbox"/>	<input type="checkbox"/>
Intermittent explosive disorder	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
<b>Would/Might be in best interest for child to:</b>		
Meet birth parents	<input type="checkbox"/>	<input type="checkbox"/>
Have contact with birth parents through agency or intermediary	<input type="checkbox"/>	<input type="checkbox"/>
Send letters to birth parent	<input type="checkbox"/>	<input type="checkbox"/>
Receive letters from birth parents	<input type="checkbox"/>	<input type="checkbox"/>
Send videos to birth parents	<input type="checkbox"/>	<input type="checkbox"/>
Receive videos from birth parents	<input type="checkbox"/>	<input type="checkbox"/>
Have phone contact between adults	<input type="checkbox"/>	<input type="checkbox"/>
Continue visits with siblings	<input type="checkbox"/>	<input type="checkbox"/>
Continue visits with extended relatives in birth family	<input type="checkbox"/>	<input type="checkbox"/>
Receive birth parents' name, address, phone number, etc.	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
<b>Family Preference</b>		
Single Parent: preferred	<input type="checkbox"/>	<input type="checkbox"/>
Single Parent: willing to consider	<input type="checkbox"/>	<input type="checkbox"/>
Two Parent: preferred	<input type="checkbox"/>	<input type="checkbox"/>
Two Parent: willing to consider	<input type="checkbox"/>	<input type="checkbox"/>
Child is open to same sex parents: Male	<input type="checkbox"/>	<input type="checkbox"/>
Child is open to same sex parents: Female	<input type="checkbox"/>	<input type="checkbox"/>
Needs to be only child	<input type="checkbox"/>	<input type="checkbox"/>
No other females in home	<input type="checkbox"/>	<input type="checkbox"/>
No other males in home	<input type="checkbox"/>	<input type="checkbox"/>

Remarks: (explain the above topics, as needed. Specify and explain any other factor/conditions you could accept in a child(ren)'s background).