



YOUTH FIRE INTAKE REPORT (rev. 2022-06-28)

Youth Information

Youth First Name: _____ Middle Name: _____ Last Name _____

Age at Time of Incident: _____ Date of Birth: _____ Gender: _____

Youth Height: (X'XX" - feet/inches) _____ Youth Weight: (lbs.) _____ Race: _____

Is the Youth a Smoker? Yes or No _____ Primary Language Spoken at Home: _____

Youth Primary Contact Phone: (_____) _____ Phone Type: Home or Cell

Youth Email Address: _____

Grade in School at Time of Incident (list advancing grade if incident occurred over summer): _____

School Name: _____

Youth Social Media Accounts used (check all that apply):

- | | | | |
|-----------------------------------|------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Instagram | <input type="checkbox"/> Tumblr | <input type="checkbox"/> YouTube |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> LinkedIn | <input type="checkbox"/> Twitter | <input type="checkbox"/> Vine |
| <input type="checkbox"/> Google+ | <input type="checkbox"/> Pinterest | <input type="checkbox"/> Other _____ | |

Caregiver Information

Family Type of Youth: (Birth parents, single parent divorced, adopted, etc.) _____

Primary Custodial Caregiver First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary Phone: (_____) _____ Cell or Home Secondary Phone: (_____) _____ Cell or Home

Primary Caregiver's Highest Level of Education (check all that apply):

- | | | | | |
|--------------------------------------|------------------------------|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> High School | <input type="checkbox"/> GED | <input type="checkbox"/> Some college | <input type="checkbox"/> BA or BS degree | <input type="checkbox"/> Masters |
|--------------------------------------|------------------------------|---------------------------------------|--|----------------------------------|

Secondary Custodial Caregiver First Name: _____ Last Name: _____

Email: _____

Primary Phone: (_____) _____ Cell or Home Secondary Phone: (_____) _____ Cell or Home

Youth / Family Residence

Number of Children in Primary Family/Residence: _____

Name of Sibling: _____ Age: _____ Gender _____

Name of Sibling: _____ Age: _____ Gender _____

Name of Sibling: _____ Age: _____ Gender _____

Name of Sibling: _____ Age: _____ Gender _____

Does Youth Participate in Free/Reduced Lunch Program? Yes or No

Smokers in Household? Yes or No

Health History / Youth Info

Medical Condition or Mental Health Diagnosis (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Impulse Control (Aggression) Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Obsessive/Compulsive Disorder |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder | <input type="checkbox"/> Oppositional Defiance Disorder |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Specific Learning Disorder |
| <input type="checkbox"/> Conduct Disorder | <input type="checkbox"/> Trauma/Stress Related Disorder (PTSD) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Developmental (Intellectual) Disability | |
| <input type="checkbox"/> Other (Please state): _____ | |

Current Medical or Mental Health Treatments Being Provided (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Counseling/Therapy | <input type="checkbox"/> Youth Law Enforcement History |
| <input type="checkbox"/> Abuse / Neglect History | <input type="checkbox"/> Family Law Enforcement History |
| <input type="checkbox"/> Child Protective Services History | <input type="checkbox"/> School Performance or Behavioral History |

Other Agencies Working with Family (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Child/Family Services Diversion | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Juvenile Justice Law Enforcement | <input type="checkbox"/> Other |

Other / Details: _____

Recent (within 6 months) Stressful Event in Family (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Move/Relocation |
| <input type="checkbox"/> Bullying/Teasing-Victim or Perpetrator | <input type="checkbox"/> New Child/Family Member |
| <input type="checkbox"/> Death of Family Member | <input type="checkbox"/> Parental Separation/Divorce |
| <input type="checkbox"/> Economic Change in Family Income | <input type="checkbox"/> School Change |
| <input type="checkbox"/> Loss/Death of Friend/Pet | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other(please list) _____ | |

Other / Details: _____

Has The Youth Had Previous Firesetting Incidents? Yes or No How many fires do you know of? _____

Most Recent Fire Incident Date: _____ Incident Day of the Week: _____

Incident Time of Day: _____ Incident City: _____ Incident Zip: _____

Incident Location: _____

Ignition Source: _____ First Item Ignited: _____

Obtained Ignition Source From: _____

Accelerant(s) Used in Incident (check all that apply):

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Aerosol Sprays | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Butane |
| <input type="checkbox"/> Diesel | <input type="checkbox"/> Fireworks/Flash Powder | <input type="checkbox"/> Gasoline | <input type="checkbox"/> Gunpowder |
| <input type="checkbox"/> Hand Sanitizer | <input type="checkbox"/> Spray Deodorant/Hair Spray | <input type="checkbox"/> Natural Gas | <input type="checkbox"/> Propane |
| <input type="checkbox"/> Lighter Fluid | <input type="checkbox"/> Other Pressurized Gas | <input type="checkbox"/> Lighter Fluid | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other(Please list) _____ | | | |

Description of Fire Incident: (What happened?)

Was the Youth Arrested and/or Cited by Authorities? Yes or No

What was the charge? _____

Disciplinary Actions Resulting from Fire Incident: _____

Was the Youth Under the Influence of Substances at the Time of the Incident? Yes or No

Was Media or Social Media an Influence at the Time of the Incident? Yes or No

Who was the Caregiver/Guardian at the Time of the Incident? _____

Were there Associates Involved in the Incident? Yes or No

Were there injuries as a result of the incident? Yes or No

Number of People Displaced by Incident: _____ Death Resulting from Incident: Yes or No

Was there property damage as a result of the incident? Yes or No

Did the fire department respond for this fire? Yes or No