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Child & Adolescent Clinical Assessment

[PLEASE PRINT OR WRITE CLEARLY]

Client's name: _____ Date of birth: _____Age: _____ Date: _____

Gender: ____F ____ M Address: _____City: _____State: ____

Zip: _____ Phone (home): _____(cell): _____ (work): _____ Ext: ____

Form completed by (if someone other than client): _____

Reason for Referral

Current Behaviors, Problems, Symptoms and Situational Needs (check all that apply)

__ Sad/Depressed Mood	__Weight loss/gain	__Mood Swings	__Tearful
__Feelings of guilt/worthless	__ Irritability	__Angry	__Elevated Mood
__Anxious/Nervous	__Obsessive/compulsive	__Panic Attacks	__Memory Impairment
__Phobia(s)	__Impulsivity	__Hyperactivity	__Judgment Errors
__Poor concentration	__Inattentive	__Fidgety	__Cyber Addiction
__Verbally abusive	__Physically assaultive	__Lying	__Defiant
__Stealing	__Oppositional	__Substance use/abuse	__Chest Pain
__Sexual acting out	__Eating Disorder	__Poor social skills	__Poor self-care
__Suicidal Ideation	__Hallucinations	__Bed wetting (Enuresis)	__Heart Palpitations
__Fecal Soiling (Encopresis)	__Hypersomnia (excessive sleeping)		__Insomnia (difficulty sleeping)
__Appetite Increase/Decrease	__Disorientation	__Loneliness	

Comments/Additional Information:

Family/Social History

Current Legal Guardian(s): _____

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

Were the child's parents ever married? _____ Yes _____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? _____Yes _____ No

If Yes, describe: _____

If you are divorced or separated and you share custody, list days and times your child is with you and the other parent:

Mother_____

Father_____

Child's Mother

Name: _____ Age: ____ Occupation: _____ ___ FT __ PT

Where employed: _____Mother's education: _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?____Yes ____No

If Yes, please explain: _____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Child's Father

Name: _____ Age: ____ Occupation: _____ _____ FT _____ PT

Where employed: _____Father's education: _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

__ Yes ___ No If Yes, please explain: _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	*Age*	*Gender*	*Lives*	*Quality of Relationship with the client*
_____	___	___ F ___ M	___ home ___away	___ poor ___ average ___ good
_____	___	___ F ___ M	___ home ___ away	___poor ____ average ___ good
_____	_____	F ___ M	___ home ___away	___poor ____ average ___ good
_____	___	___ F ___ M	___ home ___away	___poor ____ average ___good

Does your child have her/his own bedroom? ___Yes ___No If no, describe sleeping arrangement:_____

_____

Does your child sleep in his/her own room? ___Yes, always ___No, never ___Sometimes

Please explain sleeping arrangements:_____

Others living in the household		*Relationship (e.g., cousin, foster child)*	
_____	___ ___ F ___ M	_____	___ poor __ average __ good
_____	___ ___ F ___ M	_____	___ poor __ average __ good
_____	___ ___ F ___ M	_____	___ poor __ average __ good

Comments: _____

How many times has your child moved? _____Describe below (places, dates, circumstances):

_____

_____

Family History of Mental Illness, Substance Abuse, and Trauma

Is there a history of alcohol and drug problems in your family? _____Yes _____No

If Yes, describe: _____

Is there a there a history of mental health problems in your family(e.g., ADHD, Depression, etc)? ___Yes ___No

If Yes, describe:_____

Is there a history of violence in your family (i.e., pushing, hitting, threatening, etc.)? _____Yes _____No

Comments:_____

Culture, Ethnicity, & Spirituality

Please describe aspects of your culture, ethnicity, and spirituality that are relevant to your child's history**:**

_____

_____

Developmental History

Mother's age at beginning of pregnancy:_____

Complications during pregnancy, labor, and/or delivery. _____Yes ____ No

If Yes, describe: _____

Baby's birth weight/length: _____Describe any complications for the mother or the baby after the birth: _____

_____

How long was the active labor?_____ Infant's Apgar Score at birth (if known) _____

During Pregnancy Mother Used (mark all that apply)

___Antianxiety Medications (e.g., Valium, Xanax) ___Tranquilizers

___Antiseizure Medications (e.g., Dilantin) ___Sleeping Pills

___Antidepressants (e.g., Zoloft, Elavil) ___Antibiotics

___Alcohol (If yes, describe amount and frequency):_____

___Smoked Cigarettes (If yes, describe amount and frequency):_____

___Other Drugs (e.g., marijuana, cocaine,etc) Please describe amount and frequency:_____

___Other prescription or nonprescription medications (Describe):_____

Developmental Milestones (Please check corresponding ages for meeting these developmental milestones)

Sat alone: 3-6 months ___ 7-12 months___ Over 12 months ___ Don't know___

Crawl: 6-12 months___ 13-18 months___ Over 18 months___ Don't know ___

Took 1st Steps: 8-12 months___ 13-18 months___ 18-24 months___ Over 2years ___ Don't Know____

Spoke words: 9-12months___ 13-18 mos ___ 19-24 mos ___ 25-36 mos____ 37-48mos____ Don't Know____

Spoke Sentences: 9-12 mos ___ 13-18 mos ___19-24 mos ___25-36 mos____37-48mos___Don't Know___

- Please note any deviations from normal ranges on these developmental milestones (Put an **'A' for Advanced** and a **'D' For Delayed**):

_____Toilet Trained _____Rode two-wheeled bike _____Feed Self _____Dress Self_____ Tied shoelaces

Was your child an easy baby? __Yes __No Did your baby cry a lot?___Yes ___No
Describe (Very easy to care for, easy, average, difficult, very difficult, etc.; comment as needed): _____

_____

_____

History of Abuse/Trauma (include history of abuse, significant losses & impact on client's current functioning) __Yes __No

If yes, what kind(s) of abuse? __Physical ___Neglect ___Sexual ___Psychological/Emotional

The age of the patient a the time of the abuse:_____ Report was filed: _____Yes ____No ____Not Sure
Approximate Date:_____ Report was: _____Founded_____Unfounded_____Not Sure

Action taken if founded:_____

Relationship of the perpetrator to the patient:_____

Does the child have any contact with the perpetrator:_____

Comments:_____

_____

Current Risk for Abuse

__precocious play/talk __possible physical abuse __possible sexual abuse/risk __parental concern/fear of abuse

Comments:_____

Educational History

Current School:_____Grade_____School Contact Person:_____

School Phone Number:_____School Counselor:_____

Type of School: __ Public __ Private __ Home schooled ___Other (specify): _____

Special Education: ___ None___ED___LD___OHI___MIMD___MOMD___Other

If Other, describe:_____

In gifted program? ___Yes ___No If Yes, describe: _____

Has child ever been held back in school? ___Yes ___No If Yes, describe: _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? ___ Yes ___No If Yes, describe: _____

Has the child been tested psychologically? _____Yes ____No If Yes, describe: _____

(*If so, please provide a copy of the report. If you do not have a copy of the report, you will be asked to sign a release of information form at your intake session so that a copy may be obtained.)*

Child's Peer Relationships: (check all that apply)

__ Relates well to peers	__Follower	__Bullies others	__Shares easily
__ Has significant friendships	__Leader	__Seeks Negative attention	__Aggressive/fights
__Visits at friend's home	__Rejected/teased by peers	__Isolates self	__Solitary interests
__Has boyfriend/girlfriend	__Age-appropriate hobbies	__Impulsivity problems	__Manipulative with peers

Other Information: _____

_____

Medical History

__Yes __No Serious or Chronic Conditions of Parents: _____

__Yes __No Serious or Chronic Conditions of Siblings: _____

__Yes __No Handicaps/Disabilities/Functional Limitations: _____

__Yes __No Communication Needs (Speech, Language, and Hearing):_____

__Yes __No Vision Problems: _____

__Yes __No Allergies/Sinusitis: _____

__Yes __No Recent Physical Complaints/Current Illnesses:_____

__Yes __No Past Serious Illnesses/Injuries:_____

__Yes __No Chronic Conditions/Infectious Diseases: _____

__Yes __No Head Injury Requiring Medical Care: _____

__Yes __No Hospitalizations: _____

Most recent examinations

Name of pediatrician:_____

Type of examination	*Date of most recent visit*	*Results*
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Substance Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes ___ No

If Yes, describe: _____

_____

Criminal Justice History

Criminal Behavior? ___Yes ___No Court Involvement? ___Yes ___No Contact Person:_____

Describe criminal justice involvement (Include current legal charges, upcoming court dates, time spent in detention, previous commitment, probation status):_____

Have you , your child, or any member of your family ever appeared in court? ___Yes ___No

If yes, describe:_____

Have Child Protective Services, the Domestic Violence Unit, Adult Protective Services, and or any other social service government agencies ever been involved with your child or your family? If yes, describe:_____

_____

Have you, your child or any member of your family ever been arrested or spent time in jail/prison? If yes, describe: ___

_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Dates	Treatment Location	Symptoms
Counseling/Psychiatric Treatment	___to___	_____	_____
Drug/Alcohol Treatment	___to___	_____	_____
Psychiatric Hospitalizations	___to ___	_____	_____

Do you feel that therapy was helpful previously? ___ Yes ___No

Please explain your answer:_____

Risk Assessment

Do you believe your child is suicidal at this time ?_____Yes _____No

If Yes, explain:_____

Has your child ever engaged in self-injurious behavior ?_____Yes _____No

If Yes, explain: _____

Please note any additional information regarding a family history of suicide, risk-taking behaviors exhibited by your child, etc: _____

_____

Strengths, Abilities, & Interests

__Creative	__Honest	__Logical	__Friendly	__Dependable	__Polite
__Independent	__Academic success	__Advocates for self	__Goal oriented	__Athletic	__Helpful
__Social	__Artistic	__Sense of humor	__Kind	__Problem-solver	
__Supportive family	__Self-aware	__Musical	__Adaptable	__Physically healthy	

Other: _____

Any additional information that you believe would assist us in understanding your child/adolescent or current concerns or problems? _____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____