Initial Assessment - Child(4-16 years old)

Date: ____________________ Parent/Guardian: ____

Child Name: ___________________________________ Cell Phone: ____

Child Age: ______________________ Email: ____

Please list everyone who lives in the home and his/her relationship to child: __________________________

____

What are your child's strengths, interests, and/or hobbies? ____

____

____

What are the concerns/issues that bring you to therapy today? ____

____

____

____

When did these behaviors begin?_________________________

How frequently do these behavior occur? _____________________________________

On a scale from 1-10 how much do these behaviors impact the child's daily routine/functioning?

1 2 3 4 5 6 7 8 9 10

What strategies have you tried to address these behaviors? ____

____

____

What changes are you hoping to see in therapy? ____

____

How hopeful are you about seeing improvement in your child?

1 - Not at all hopeful 2 - a little hopeful 3 - somewhat hopeful 4 - very hopeful

If you are not hopeful, why not? ____

____

Medical History

Is your child currently under the care of a physician? yes no

Name of Physician ______________________________

Date of last visit ______________________________

Are your child's immunizations up to date? yes no

Has your child ever undergone surgery? yes no

If yes please explain: ____

Does your child have any allergies? yes no

If yes please explain: ____

Please list current medical conditions your child is being treated for and date of diagnosis: ____

Current medications being prescribed:	Dosage	Frequency	Improvement Noticed

Does your child have any trouble falling asleep? yes no

Does your child have any trouble staying asleep? yes no

Is your child easy to wake up in the morning? yes no

Usual bedtime: ___________________

Usual Wake Time: ___________________

Does your child experience nightmares/terrors? yes no

Comments/Explanation of Positive Responses:

Have you noticed any changes in your child's appetite/eating habits? yes no

If yes, please explain: ____

What form of discipline is used in the home:

____

____

Does your child respond to discipline? yes no

Birth History & Development

Mother's Age at time of Pregnancy	________	
Father's Age at time of Pregnancy	________	
Planned Pregnancy	yes	no
Known use of drugs/alcohol during pregnancy	yes	no
Medical Problems/Complications during pregnancy	yes	no
Prenantal Care	yes	no
Full Term Pregnancy	yes	no
Birth Weight	________	
Complications at delivery for child	yes	no
Complications at Delivery for Mother	yes	no
Did baby stay more than 5 days in Hospital	yes	no
Follow up Child Care	yes	no
Post-Partum Depression for Mother	yes	no
Follow up care for Mother	yes	no

COMMENTS/Explanation of Positive Responses:

Early Development of Child

Was growth and weight gain normal	yes	no
Was there any Failure to Thrive	yes	no
Was child colicky	yes	no
Age when child:		
sat up independantly	________	
crawled	________	
walked	________	
spoke words	________	
spoke sentences	________	
Age when fully toilet trained	________	
Any concerns about Global Development Delay	yes	no
Any current enuresis or encopresis	yes	no

COMMENTS/Explanation of Positive Responses:

Family History of Mental Illness

Please identify any family members with a mental health diagnosis and/or substance abuse issues:

____

____

____

____

Psychiatric Social History

Was child adopted?	yes	no		
Relationship status of biological parents	married	divorced	separated	never married
Loss of parent by death prior to age 18	yes	no		
Would you descibe childhood as	happy	average	unhappy	
How would you describe socio-economic status	lower	middle	upper economic class	
Has this child experienced any of the following:				
Emotional abuse	yes	no		
Physical abuse	yes	no		
Sexual abuse	yes	no		
Has child ever witnessed violence or been involved in violent episode?	yes	no		
Comments/Explanation of Positive Responses:				

Education

Current School: ____

Grade: ________________ Teacher: _________________________________

Does your child enjoy school? Yes No

Academic performance: failing poor average above average

Has child ever repeated a grade? Yes No

Has child been suspended/expelled? Yes No

If yes, please explain: ____

Does your child have an IEP/receive Special Education Services? (including Speech) Yes No

If yes, what accomodations are being provided? ____

Does your child have problems with teachers/authorities? Yes No

If yes, please explain: ____

Social

Does your child make friends easily? Yes No

How woud you describe the nature of his/her friendships? Good Average Poor

Is the child involved in community activities/after school activities? Yes No

Does your family participate in community activities? Yes No

Does the child usually attend religious services with the family? Yes No

COMMENTS/Explanation of Positive Responses:

Legal History

Is custody of child with biological family	yes	no
Past DCS involvement or services	yes	no
Any past Foster Care placement	yes	no
Has the child ever been arrested	yes	no
Any past placement in Detention	yes	no
Any past placement in a YDC	yes	no
COMMENTS/Explanation of Positive Responses		

Past Psychiatric History

Prior out patient psychiatric treatment in the past?	yes	no
Prior out patient alcohol/substance abuse treatment?	yes	no
Prior outpatient treatment was helpful?	yes	no
Number of prior psychiatric hospitalizations:	________	
Date of last psychiatric hospitalization:	________	
Involuntary hospitalizations in past?	yes	no
Other levels of Care	yes	no
History of non-suicidal injury (scratching, cutting, burning)?	yes	no
Method of self harm:	________________	
Prior History of suicide attempt?	yes	no
Number of attempts	________	
Last attempt was:	________	
Attempt resulting in medical hospitalization:	yes	no
Prior History of Aggression or Violence?	yes	no
Aggression towards:	________________________	
Legal charges stemming from aggression:	yes	no
Incarceration stemming from aggression:	yes	no

Please identify any current stressors in the home that may be impacting your child: ________________________

____

____

Please provide any current or past use of substances (parent) | | | **If yes, how much how often?**

Please provide any current or past use of substances (parent)			If yes, how much how often?
Alcohol: (beer, wine, liquor)	yes	no	
Cannabinoids: (marijuana, hashish)	yes	no	
Opioids and Morphine Derivatives: (codeine, morphine, Heroin, opium)	yes	no	
Stimulants: (cocaine, amphetamines, methamphetamines)	yes	no	
Club Drugs: (MDMA, GHB, Flunitrazepam)	yes	no	
Dissociative Drugs: (Ketamine, PCP, Dextromethorphan Salvia)	yes	no	
Depressants: (barbiturates, benzodiazepines)	yes	no	
Hallucinogens: (LSD, Psilocybin, Mescaline)	yes	no	
Anabolic steroids: (depo-testosterone, anadrol)	yes	no	
Inhalants: (huffing, glue, solvents etc)	yes	no	
Intravenous drug use	yes	no	
Have you had any difficulties with any of the following issues related to substance use?	yes	no	
TOLERENCE (increased amount of substance required to obtain initial effect of the drug)	yes	no	
WITHDRAWAL (symptoms of physiologic or psychological distress upon stopping or reducing the amount of drug used)	yes	no	
consumption exceeds intented amount	yes	no	
efforts to reduce/control consumption	yes	no	
excessive time spent related to substance use and leading to disruption of daily functioning	yes	no	

Domestic Violence Screening (parent)

Have you been emotionally or physically abused by your partner or someone close/important to you	yes	no
Have you ever been hit, kicked, punched or otherwise hurt by someone close/important to you within the past year	yes	no
Do you feel safe in your current relationship	yes	no
Is there a partner from a previous relationship who is making you feel unsafe now	yes	no
Was Victim Services information provided to client/family	yes	no
COMMENTS/Explanation of Positive Responses		

Legal Issues (parents/guardians)

Prior difficulties with the legal system ever?	yes	no
Prior incarcerated	yes	no
Current legal issues?	yes	no
Currently on Disability?	yes	no
Currently seeking Disability?	yes	no
COMMENTS/Explanation of Positive Responses		

Education & Employment

Mother's Highest Grade Completed: ____________________

Father's Highest Grade Completed: ______________________

Please explain any difficulty parents had in school? ____

____

Do parents work outside the home? Yes No

Please provide name of employer and hours worked/schedule:

____

____

Please check all that apply

- ☐ Excessive/unrealistic worry
- ☐ Motor tension (restlessness, shakiness)
- ☐ Hypervigilance
- ☐ Social anxiety
- ☐ Separation anxiety
- ☐ Panic attacks
- ☐ Sleep disturbances

- ☐ Verbal aggression
- ☐ Physical aggression
- ☐ Mood swings
- ☐ Impulsive
- ☐ Low frustration tolerance
- ☐ Lying/Cheating/Stealing
- ☐ Defiance
- ☐ Argues with authority
- ☐ Sibling conflict
- ☐ Peer conflict
- ☐ Cussing/Inappropriate Language

- ☐ Difficulty paying attention to details
- ☐ Has difficulty sustaining attention
- ☐ Often does not seem to listen when spoken to directly
- ☐ Often unable to follow through on tasks
- ☐ Trouble with organization
- ☐ Avoids tasks requiring sustained mental effort
- ☐ Often loses things necessary for completing tasks
- ☐ Easily distracted
- ☐ Forgetful in daily activities

- ☐ Depressed mood
- ☐ Irritable
- ☐ Withdraws/isolates
- ☐ Suicidal thoughts or actions
- ☐ Disinterest in previously enjoyed activities
- ☐ Low energy, easily tired
- ☐ Significant weight loss or gain
- ☐ Low self-esteem
- ☐ Feelings of hopelessness
- ☐ Inappropriate guilt
- ☐ Unresolved grief issues
- ☐ Hallucination or delusions

- ☐ Fidgets/squirms
- ☐ Has trouble staying seated
- ☐ Excessive running/climbing or restlessness
- ☐ Trouble with quiet activities
- ☐ Needs to be “on the go”
- ☐ Often talks too much
- ☐ Blurts out answers
- ☐ Difficulty awaiting turn
- ☐ Interrupts conversations or intrudes on others