Child/Adolescent Assessment

(to be completed by parent/guardian)

Please provide the following information in preparation for your interview with your mental health clinician.

DATE:

CHILD'S NAME (FIRST, LAST)

CHILD'S D.O.B./AGE

CHILD'S GENDER: ☐ Female ☐ Male ☐ Other: _____

PREFERED PRONOUNS: ☐ She/Her ☐ He/Him ☐ Other: _____

CHILD'S PHONE NUMBER: _____
OK to leave VM ☐ YES ☐ NO
OK to text ☐ YES ☐ NO

Child's Email: _____
OK to send you email ☐ YES ☐ NO
*please note: email correspondence is not considered to be a confidential means of communication

CHILD'S LEVEL OF EDUCATION**:** ☐ Elementary School
☐ Middle School
☐ High School
☐ GED
☐ Other: _____

NAME OF CHILD'S SCHOOL**:** _____
CHILD'S PLACE OF EMPLOYMENT**:** _____

5 WORDS TO DESCRIBE YOUR CHILD: _____

3 OF YOUR CHILD'S STRENGTHS: _____

Emergency Contact (Name and phone number): _____
Hospital Preference: _____

Parent/Guardian Name: _____
Phone: _____
OK to leave VM ☐ YES ☐ NO
OK to text ☐ YES ☐ NO

Email: _____
OK to send you email ☐ YES ☐ NO
*please note: email correspondence is not considered to be a confidential means of communication

Parent/Guardian Name: _____
Phone: _____
OK to leave VM ☐ YES ☐ NO
OK to text ☐ YES ☐ NO

Email: _____
OK to send you email ☐ YES ☐ NO
*please note: email correspondence is not considered to be a confidential means of communication

REASON FOR BRINGING YOUR CHILD HERE TODAY

Living Situation

Parent's Home	**Residential Care/Treatment Facility****	**Other****
☐ RENT ☐ OWN	☐ HOSPITAL ☐ TEMPORARY HOUSING ☐ RESIDENTIAL CARE ☐ NURSING HOME	☐ FRIEND'S HOME ☐ RELATIVE'S HOME ☐ HOMELESS

****IDENTIFY PERSON'S NAME OR FACILITY**

Primary Household					
Household member name	Relationship to child	Age	Job/School	Highest level of education	Quality of relationship

STREET ADDRESS

Does the client live in more than one household?
☐ **NO** If no, skip to "Additional Family Members." ☐ **YES** If yes, complete the "Secondary Household" information below.

Secondary Household					
Household member name	Relationship to child	Age	Job/School	Highest level of education	Quality of relationship

STREET ADDRESS

Family members who live in both households
☐ ONLY CHILD
☐ CHILD and (list): _____

Additional family members
☐ NO parents or sibling other than those listed in Primary or Secondary Households
☐ YES, please list family members: _____

Custody and parenting plan
☐ LIVES WITH BOTH PARENTS (biological or adoptive) in same household

☐ SINGLE PARENT
☐ SHARED CUSTODY - parents in different households
☐ OTHER (describe): _____
_____

Development

Have you ever had concerns about the following with this child?

Pregnancy	Yes	No	Unknown
Had bleeding	☐	☐	☐
Had toxemia	☐	☐	☐
Got injured or hurt	☐	☐	☐
Took illicit drugs and/or drank alcohol	☐	☐	☐
Had an infection	☐	☐	☐
Smoked during pregnancy	☐	☐	☐
Length of pregnancy: _____ months			☐
Other pregnancy problems/Illnesses/concerns Specify: _____ _____	☐	☐	☐

Birth/Early Infancy	Yes	No	Unknown
Born prematurely	☐	☐	☐
Injury at birth	☐	☐	☐
Had trouble breathing and/or needed oxygen	☐	☐	☐
Was a twin or triplet	☐	☐	☐
Had an infection	☐	☐	☐
Had seizures (fits, convulsions)	☐	☐	☐
Was very jittery	☐	☐	☐

Childhood Health	Yes	No	Unknown	If yes, age first noted	If yes, still occuring?
Seizures (convulsions) or spells	☐	☐	☐		☐
High fever	☐	☐	☐		☐
Head injury	☐	☐	☐		☐
Asthma	☐	☐	☐		☐

Trouble with hearing	☐	☐	☐		☐
Trouble with vision	☐	☐	☐		☐
Poisoning or overdose	☐	☐	☐		☐
Serious illness	☐	☐	☐		☐
Hospitalization	☐	☐	☐		☐
Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occuring?
Poor appetite	☐	☐	☐		☐
Constipation	☐	☐	☐		☐
Stomach aches	☐	☐	☐		☐
Trouble falling asleep	☐	☐	☐		☐
Trouble staying asleep	☐	☐	☐		☐
Overactivity	☐	☐	☐		☐
Head banging	☐	☐	☐		☐
Rocking in bed	☐	☐	☐		☐
Self-destructive behavior	☐	☐	☐		☐
Difficulty in being comforted or consoled	☐	☐	☐		☐
Stiffness or rigidity	☐	☐	☐		☐
Looseness or floppiness	☐	☐	☐		☐
Crying often and easily	☐	☐	☐		☐
Shyness	☐	☐	☐		☐
Irritability	☐	☐	☐		☐
Extreme reaction to noise or sudden movement	☐	☐	☐		☐
Attention	Yes	No	Unknown	If yes, age first noted	If yes, still occuring?
Can concentrate for only a short time unless things are very interesting	☐	☐	☐		☐
Understands the main ideas of things but misses important details	☐	☐	☐		☐
Does work or performs many tasks carelessly without thinking	☐	☐	☐		☐

Learns a new skill well one day and then can't seem to do it a few days later	☐	☐	☐		☐
Receives very unpredictable (inconsistent) grades or test scores in school	☐	☐	☐		☐
Can work well only on things they really enjoy doing or thinking about	☐	☐	☐		☐
Often doesn't notice when they make mistakes	☐	☐	☐		☐
Seems not to realize when they are disturbing someone	☐	☐	☐		☐
Doesn't do much better after punishment or correction	☐	☐	☐		☐
Makes comments about or is distracted by background noises or unimportant things	☐	☐	☐		☐
Seems to want things right away and/or is hard to satisfy	☐	☐	☐		☐
Annoys or bothers other children	☐	☐	☐		☐
Behavior is hard to predict	☐	☐	☐		☐
Bullies others	☐	☐	☐		☐
Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occuring?
Has bad dreams	☐	☐	☐		☐
Is often very quiet or withdrawn	☐	☐	☐		☐
Is often down on themself	☐	☐	☐		☐
Is often tired	☐	☐	☐		☐
Speaks unclearly, stutters, or stammers	☐	☐	☐		☐
Wets bed or pants often	☐	☐	☐		☐
Soils underwear or has accidents with bowel movements	☐	☐	☐		☐
Is often too neat or orderly	☐	☐	☐		☐
Is often too concerned about cleanliness	☐	☐	☐		☐
Often plays with matches	☐	☐	☐		☐
Destroys objects at home	☐	☐	☐		☐
Destroys objects away from home	☐	☐	☐		☐

Is fearless	☐	☐	☐		☐
Is cruel to animals	☐	☐	☐		☐
Is not liked by other children	☐	☐	☐		☐
Feels ill on school mornings	☐	☐	☐		☐
Has eating problems (overeats or undereats)	☐	☐	☐		☐
Is preoccupied with food or diet	☐	☐	☐		☐
Is part of a clique or gang that causes trouble	☐	☐	☐		☐
Other behaviors not noted above	☐	☐	☐		☐
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?	☐	☐	☐		☐
Have you ever had concerns about your child's sexual arousal development or behaviors?	☐	☐	☐		☐

IF THERE ARE INDICATIONS OF PROBLEMS, PLEASE EXPLAIN

_____
_____
_____
_____
_____
_____
_____

Child's school functioning

Educational classification

Does your child receive special education services? ☐ YES ☐ NO

If no, has your child ever been tested and determined not to need services? ☐ YES ☐ NO

Typical education classroom, no special services? ☐ YES ☐ NO

If no, check all that apply below.

☐ Early childhood Special Ed./Developmental Delay
☐ Autism Spectrum Disorder
☐ Traumatic brain injury
☐ Other health impaired
☐ Physically impaired
☐ Developmental/Cognitive Disability
☐ Learning Disability
☐ Developmental/Cognitive Disability
☐ Hearing impaired
☐ Visually impaired
☐ Speech or language impaired
☐ Emotional/Behavior Disorder
☐ Unsure
☐ Other: _____

COMMENTS ON EDUCATIONAL CLASSIFICATION

_____
_____
_____

Child's legal history

Does your child have a history of legal charges? ☐ YES ☐ NO
IF YES, DESCRIBE CHARGES _____ _____
Is your child currently on probation? ☐ YES ☐ NO Has your child ever been on probation? ☐ YES ☐ NO
Has your child ever been court ordered in to substance abuse or mental health treatment? ☐ YES ☐ NO

Child's trauma history

Children's Protective Services (CPS) involvement with the family? ☐ YES ☐ NO
IF YES, DESCRIBE _____ _____
NAME OF CPS CASEWORKER(S) ASSIGNED TO FAMILY (IF APPLICABLE): ☐ NONE REPORTED
NAME OF GUARDIAN AD LITEM (GAL) OR COURT APPOINTED ADVOCATE (CASA) ASSIGNED TO FAMILY: ☐ NONE REPORTED
Has your child ever experienced any of the following? ☐ YES ☐ NO ☐ Physical abuse ☐ Emotional abuse ☐ Sexual abuse ☐ Sexual/physical assault ☐ Neglect ☐ Witnessed abuse ☐ Witnessed domestic violence ☐ Community violence ☐ Bullied ☐ Any significant loss ☐ Suicide attempt ☐ Major illness ☐ Major accident/injury ☐ Natural disaster ☐ Other: _____

Child's mental health treatment history

Does your child have a mental health diagnosis? ☐ NO ☐ YES If yes, include diagnosis here _____	
Previous mental health treatment ☐ NO ☐ YES If yes, please list reason for treatment and dates:	
Reason	**Dates**
Currently on any medication(s)? ☐ YES ☐ NO	
IF YES, PLEASE LIST MEDICATION(s) (name, dosage, frequency):	
PRIMARY CARE PHYSICIAN	PHONE NUMBER
ADDRESS	FAX NUMBER

OTHER PRESCRIBING PHYSICIAN(S)	PHONE NUMBER(S)
ADDRESS	FAX NUMBER(S)

Child's alcohol and drug history

Do you have any concerns about your child's use of alcohol or drugs? ☐ YES ☐ NO
Do you have any other issues or concerns about your child that you would like to have addressed? ☐ YES ☐ NO
COMMENTS _____ _____ _____

Family environment/relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client) Relationship(s) P = Primary Household S = Secondary Household B = Both					
Parent-child conflict	____ NONE-MILD	____ MODERATE	____ SEVERE		
Issues with supervision and monitoring of child	____ ALWAYS	____ USUALLY	____ INCONSISTENTLY	____ RARELY	
Cooperation between parents re: child-rearing	____ ALWAYS	____ USUALLY	____ INCONSISTENTLY	____ RARELY	___ N/A
Parent positive activities with child	____ FREQUENT	____ OCCASIONAL	____ INFREQUENT		
Parent satisfaction with relationship	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED		
Child satisfaction with relationship	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED		
COMMENTS _____ _____ _____					

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (client) Relationship(s) ☐ NO SIBLINGS P = Primary Household S = Secondary Household B = Both			
Child-sibling conflict	____ NONE-MILD	____ MODERATE	____ SEVERE
Sibling(s) positive activities with child	____ FREQUENT	____ OCCASIONAL	____ INFREQUENT
Sibling(s) satisfaction with relationship	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED

Child satisfaction with relationship	____ NONE-MILD	____ MODERATE	____ SEVERE
COMMENTS _____ _____ _____			

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s) ☐ NOT APPLICABLE P = Primary Household S = Secondary Household B = Both			
Marital or couple conflict	____ NONE-MILD	____ MODERATE	____ SEVERE
Marital or couple satisfaction	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED
COMMENTS _____ _____ _____			

Other Family Concerns			If yes, indicate:		
	NO	**YES**	Parent	Sibling	Other
Family member health problem	☐	☐			
Family member disability	☐	☐			
Family member legal issues	☐	☐			
Family financial concerns	☐	☐			
Family member alcohol abuse	☐	☐			
Family member substance abuse	☐	☐			
Family member anxiety	☐	☐			
Family member depression	☐	☐			
Family member mania	☐	☐			
Family member schizophrenia/other psychosis	☐	☐			
Significant family stressors (moves, deaths, divorce, loss of employment)	☐	☐			
COMMENTS ON OTHER FAMILY CONCERNS _____ _____ _____					