CHILD/ADOLESCENT FORM

Client Name: _____ Age: ____ DOB: _____

Gender: □ Male □ Female □ Other: _____

Preferred Name/Nickname: _____

PRESENTING PROBLEM: (Briefly describe the issues/problems which led to your decision to seek therapy services). Use Back if need more room for description.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How severe, on a scale of 1-10 (with 10 being the most severe), do you rate your child's presenting problems?

LEAST 1 2 3 4 5 6 7 8 9 10 MOST

PRESENTING PROBLEM CATEGORIZATION: (Please check all that apply) Symptoms causing concern, distress or impairment:

□ Change in sleep patterns (describe)_____

□ Concentration: (describe) _____

□ Change in appetite: (describe) _____

□ Hygiene/grooming (describe) _____

□ Increased Anxiety (describe): _____

_____

□ Panic symptoms (describe):_____

_____

□ Mood Swings (describe): _____
_____

□ Aggression (describe): _____

□ Activities/play (describe): _____

□ Social Relationships (describe) _____

_____

□ Behavioral Problems/Changes (describe): _____
_____
_____

□ Victimization (please circle): Physical abuse Sexual abuse Psychological Abuse Robbery victim Assault victim Dating violence Domestic Violence Human trafficking DUI/DWI crash Survivors of homicide victims

Other: _____

Any other areas of concern? _____

_____

_____

How long has this problem been causing your child distress? (Please circle)

1 week 1 month 1 – 6 Months 6 Months – 1 Year Longer than 1 year

How do you rate your child's current level of coping on a scale of 1 – 10 (with 1 being unable to cope)?

UNABLE TO COPE 1 2 3 4 5 6 7 8 9 10 ABLE TO COPE

CURRENT FUNCTIONING

Please rate your child's personality/temperament (how they behave the majority of the time in each of the following areas on a scale from 1 to 10 by circling the number that best describes your child)

ENERGY/ACTIVITY LEVEL (how active is my child?)

CANT sit still and listen CAN sit still and listen

1 2 3 4 5 6 7 8 9 10

NEED FOR PHYSICAL ROUTINE (how much routine does my child need)?

Needs Routine (easily upset when things don't go as usual) Easily adjusts to changes and disruptions

1 2 3 4 5 6 7 8 9 10

MOOD (what is my child's mood most of the time)?

Anxious (usually frustrated and worried) Calm (relaxed-easy going)

1 2 3 4 5 6 7 8 9 10

Sad (down, difficulty having fun) Happy (enjoys most things)

1 2 3 4 5 6 7 8 9 10

Timid (little interest in others) Outgoing (curious and social)

1 2 3 4 5 6 7 8 9 10

Angry (easily irritated, annoyed or upset) Content (peace keeper, Chill)

1 2 3 4 5 6 7 8 9 10

INTENSITY (how strongly does my child express feelings, wants and opinions?)

Strong reaction (cry/yell over small things) Mild reaction (go w/flow, no conflict)

1 2 3 4 5 6 7 8 9 10

PERSISTENCE (Can my child stick with and complete tasks?)

Gives up easily Will stick it out until task finished

1 2 3 4 5 6 7 8 9 10

SENSITIVITY TO SENSES (How sensitive is my child to light, smells, sounds, and touching?)

Learns and explores using all senses easily bothered by/strong reaction to sensory input

1 2 3 4 5 6 7 8 9 10

PERCEPTIVENESS (How aware is my child of feelings and emotions?)

Unaware of others feelings Sympathetic/empathetic to others

1 2 3 4 5 6 7 8 9 10

ADAPTABILITY (How easily does my child accept changes?

Fearful of new people/situations Eager to meet and accept new people and situations

1 2 3 4 5 6 7 8 9 10

ATTENTION SPAN/DISCTRACTIBILITY (How well does my child pay attention?)

Easily sidetracked (difficulty following instructions) Stays focused on tasks/ follows through

1 2 3 4 5 6 7 8 9 10

STRENGTHS/RESOURCES/SUPPORTS:

What limitations does your child/ family have (if any)?_____
_____

What strengths does your child/family have? _____
_____

What resources does your child have to help with your current problem? _____
_____

What experiences (past & present) will help you in improving the current situation? _____
_____
_____
_____

What are you (and your family) already doing to improve the current situation? _____
_____

Who does/can your child count on for support?

□ Parents □ Boyfriend/Girlfriend □ Siblings □ Extended Family □ Friends □ Neighbors
□ School Staff □ Church □ Pastor
□ Therapist □ Group □ Community Services □ Doctor

□ Other: _____

FAMILY COMPOSITION:

Mother's Name: _____ Age: _____
□ Living with child □ Not living with child

Employed Currently? □ Yes □ No Place of Employment: _____

Occupation: _____

Father's Name: _____ Age: _____
□ Living with child □ Not living with child

Employed Currently? □ Yes □ No Place of Employment: _____

Occupation: _____

Marital status of Parents: □ Single □ Married □ Divorced □ Widowed □ Domestic Partners

Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in- or outside the home. Please include all members currently residing in child's household.

Name	Gender	Age	Relationship To Client	Living W/Child
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No

PARENT/CHILD RELATIONSHIP

Describe parenting your child (e.g. challenging, easy): _____

What do you find most challenging in parenting your child? _____

_____

_____

What kind of discipline works best with your child? _____

_____

What else do you feel/believe would be helpful, or important for me to know/understand about your relationships with your family or about your family members? _____

_____

_____

RECENT LOSSES: □ Family Member □ Friend □ Health □ Lifestyle □ Job □ Income □ Housing □ None

Who? _____ When? _____

Nature of Loss? _____

Additional information (if needed): _____
_____

PREGNANCY, BIRTH and DEVELOPMENTAL HISTORY:

Were there any complications during pregnancy? □ Yes □ No

If yes, please explain: _____
_____

Were there any complications during birth? □ Yes □ No If yes, please explain: _____
_____

Were drugs or alcohol consumed during pregnancy? □ Yes □ No

Was your child adopted? □ Yes □ No If yes, at what age? _____

□ Domestic adoption □ International adoption (Country: _____)

As accurately as you can remember, how old was your child when she/he:

Rolled over? _____ Crawled? _____ Walked? _____ Talked (two words)? _____
Toilet Trained? _____

Do/did you have concerns about your child's development in any of these areas (below)?

□ Speech/Language □ Motor Skills □ Cognitive/Intellectual □ Sensory □ Behavioral
□ Emotional □ Social If so, please describe: _____
_____
_____
_____

Were there any significant disturbances/changes during your child's childhood? □ Yes □ No
If yes, please describe: _____
_____
_____
_____

HEALTH HISTORY

How would you describe your child's overall health? _____

Does your child have any health issues? □ Yes □ No

If yes, please list below: _____

_____

Does your child take any medications? □ Yes □ No

Please list medications (Include psychotropic, over the counter and herbal remedies) that they have taken in the last 6 months.

Medication	Frequency	Dosage	Reason	Prescribed By:

Is your child taking the medications as prescribed? □ Yes □ No

If No, please explain: _____

Additional information (if needed): _____

_____

Has your child ever had a serious accident/illness or hospitalization? □ Yes □ No

Please list all past hospitalizations, surgeries, accidents, or illnesses with any significant details and dates as best as remember: _____

_____

_____

_____

_____

When was your child's last visit with Primary Care Doctor? _____

Reason for Visit? _____

Primary Care Doctor: _____ Facility: _____

Phone Number: _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Has your child been seen by a counselor? □ Yes □ No

If yes, name of current/previous counselor(s) _____
Length of Treatment(s) _____

Interventions that were successful? _____

Interventions that were not helpful? _____

Has your child been seen by a psychiatrist? □ Yes □ No

If yes, name of current/previous psychiatrist _____

Length of Treatment(s) _____

Interventions that were successful? _____

Interventions that were not helpful? _____

Has your child ever been diagnosed with a mental health, emotional or psychological condition?
□ Yes □ No If yes, what diagnosis was your child given? _____
When? _____
By whom? _____

Has your child ever been hospitalized for mental illness or substance abuse concerns?
□ Yes □ No

If yes, Please provide further detail as to the circumstances including dates, length of stay and what, if anything, was successful about the hospitalization:_____

_____
_____
_____
_____

SAFETY CONCERNS:

Is your child presently suicidal? □ Yes □ No If Yes, please explain _____
_____

Has your child ever attempted to commit suicide? □ Yes □ No

If yes, when and how? _____
_____

Is there a history of suicide in your child's immediate and/or extended family? □ Yes □ No
If Yes, please explain _____
_____

Has your child ever inflicted burns or wound on his/herself? □ Yes □ No

Is your child presently homicidal? □ Yes □ No

If yes, please explain _____
_____

Additional Information: (please list additional information as needed to address past and current safety issues) _____
_____
_____

HISTORY OF ABUSE/NEGLECT:

Has your child ever been abused or assaulted? □ Yes □ No

If yes, please provide further details, including if it was reported/ investigated.

_____
_____
_____
_____

Has your child ever been a victim of bullying? □ Yes □ No

Do you worry about your child's safety now? □ Yes □ No

What else do you feel is important for me to know? _____
_____
_____

HISTORY OF VIOLENCE:

Has your child ever been accused of abusing or assaulting someone? □ Yes □ No

If yes, please provide further details, including if there was a report to authorities or an investigation. _____

LEGAL INVOLVEMENT

Is there or has there been any involvement with Law Enforcement? Yes □ No

If yes, please provide further details.

_____
_____
_____

Has there ever been involvement with any Child Protective Services? Yes □ No

If yes, please provide further details. _____

_____

FAMILY MENTAL HEALTH HISTORY

Please identify if any members of your family have had a history of any of the following: mental health/drug abuse/legal concerns. Include client, immediate family and maternal and paternal extended family.

Diagnosis	Which family member	Significant info regarding this
Depression		
Anxiety		
ADHD		
Bipolar		
Schizophrenia		
Trauma History		
Violent Behavior		
Alcoholism		
Drug Abuse		
Incarceration		

Additional Information: _____
_____
_____
_____

EDUCATION:

Is your child currently enrolled in school? □ Yes □ No

Name of School _____

What grade is your child currently in (if summer, was grade is your child going into)? _____
How would you describe your child's attendance (currently)? (mark ALL that apply)

Attending school regularly_____ Home Schooled _____ Some Truancy _____

Alternative Schooling _____ Suspensions _____ Expelled _____ Dropped out _____

Provide any specific details to any of the above:

_____

_____

How would you describe your child's achievement/grades in school? _____

How would you describe your child's attitude towards school/education? _____

Disciplinary or behavioral issues at school? □ Yes □ No If yes, describe: _____

_____

_____

Please check if your child has any of the following?

□ Special Education Accommodations or a 504? Please describe: _____

□ An Individualized Education Plan (IEP)? Please describe: _____

□ Diagnosed Learning Disability? Please describe: _____

□ Receiving special services at school? Please describe: _____

CURRENT NEEDS/GOALS

What do you feel is your child's biggest need right now? _____

_____

What do you most hope to gain from coming to counseling? _____

_____

If you were to pick three goals to work on, what would they be?

Goal 1: _____

Goal 2: _____

Goal 3: _____

What else would you like for me to be aware of? _____

_____

_____

_____

INDIVIDUAL(S) COMPLETING ASSESSMENT

Printed Name (primary person) _____ Date: _____

Signature _____

Relationship to child _____

Printed Name (secondary person) _____ Date: _____

Signature _____

Relationship to child _____