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Child/Adolescent Assessment

Name: _____ Date: _____

Do you or your child/adolescent have any physical impairments or limitations which may require special accommodations, special arrangements, or may affect your treatment (i.e. reading difficulties, hearing loss, vision loss, speech impairment)? ___ Yes ___ No
If yes, please explain: _____

Please describe the reason for your visit. (How long has this been a problem, what have you done to resolve this problem?)

_____
_____
_____
_____
_____
_____

What do you hope to accomplish in this initial session?

_____
_____

DEVELOPMENTAL HISTORY
PRENATAL – Were there any health or substance use issues for the mother during the pregnancy of this child? _____
_____
Was the pregnancy full term? Were there any complications?
_____

EARLY DEVELOPMENT
Do you feel your child developed at a slow, normal or rapid rate? _____
Specifically (walking, talking, sleeping alone) _____
_____
During the first three years of life, did your child exhibit any of the following?

___ Accident prone	___ Feeding problems	___ Restless behavior
___ Avoidance of contact	___ Head banging	___ Self-harm
___ Colic	___ Lack of coordination	___ Temper tantrums
___ Destructive behavior	___ Overactive	___ Distractibility
___ Unresponsive to discipline	___ Sleep problems	___ Withdrawn
___ Extreme mood shifts	___ Other	___ None of the above

Comments: _____
_____

SEXUALITY

Is your child ___ Prepubescent ___ Pubescent (Females) Menstruation began at _____

To the best of your knowledge, your child/adolescent is:

Sexually active ___ Yes ___ No ___ Unknown
Uses contraceptives ___ Yes ___ No ___ Unknown
History of pregnancy ___ Yes ___ No ___ Unknown
History of abortion ___ Yes ___ No ___ Unknown
Fathered a child ___ Yes ___ No ___ Unknown

Do you have any concerns regarding your child/adolescent's sexual development or sexual orientation?

___ Yes ___ No Comments: _____

SIGNIFICANT EVENTS

___ Change of school
___ Death in the family
___ Divorce or separation
___ Loss of someone close
___ Move to a new place
___ Serious illness or injury to family or friend
___ Frightening experience
___ Other

Comments: _____

HEALTH HISTORY

Primary Care Physician/Pediatrician _____

Current Height _____ Weight _____

Food or drug allergies _____

Childhood immunizations up to date? ___ Yes ___ No

Does your child/adolescent have any eating or sleeping problems?

_____

_____

How would you describe the nutritional value and balance of your child/adolescent's diet?

_____

Has your child/Adolescent been diagnosed or treated for any of the following?

___ ADHD
___ Anemia
___ Asthma
___ Cancer/Leukemia
___ Cerebral Palsy
___ Diabetes
___ Ear Infections
___ Encephalitis
___ Epilepsy
___ Fever above 105
___ Hearing problems
___ Heart problems
___ HIV/AIDS
___ Hydrocephalus
___ Lead Poisoning
___ Sleeps too much
___ Meningitis
___ Mental Retardation
___ Musculo-Skeletal Condition
___ Seizures
___ Vision problems
___ Other
___ None of the above

Comments: _____

_____

List any surgeries, hospitalizations or significant past health issues:

_____

Caffeine use per day _____

Weight change in the past 6 months: _____

Significant appetite change over the past month: ___ Yes ___ No Comment: _____

List all current medications:

Medication	Purpose	Dosage/x per day	When started	Do you take it consistently?

MENTAL HEALTH

Has your child ever taken medication for a mental health or emotional problem? ___ Yes ___ No

If yes, please specify which medication and what was their response? _____

_____

Has your child/adolescent ever been in therapy or other mental health or drug/alcohol treatment?

___ Yes ___ No

If yes, please list your treatment providers and facilities and approximate dates:

Provider	Dates	Provider	Dates

Describe what you know about your child's/adolescent's alcohol/tobacco/drug use:

_____

Has your child/adolescent ever experienced:

___ Physical abuse ___ Rape/sexual assault ___ Emotional abuse

___ Sexual abuse ___ Domestic violence ___ Other significant trauma

If yes, were these events reported to authorities? **(If not, I may be required to report any abuse.)**

_____

Check areas of difficulty your child/adolescent displays when performing daily activities:

___ Adapting to change
___ Attending to tasks
___ Decision making
___ Following a routine
___ Other
___ Goal setting
___ Learning
___ Self-care (hygiene, grooming, bathing)
___ Problem solving
___ None of the above

Comments: _____

EDUCATION

School presently attending _____ Grade _____

School related issues

___ Academic problems
___ Advanced a grade
___ Attendance
___ Behavior
___ Detention
___ Held back a grade
___ Homework
___ Met with school counselor
___ Peer relationships
___ Relationships with teachers
___ Required special help
___ Suspension/expulsion
___ Tested for ADD, other
___ Transportation
___ None of the above

Comments: _____

FAMILY/SOCIAL HISTORY

List all the people who currently live in the household:

Name	Age	Relationship to child/adolescent

List siblings not in the household:

Name	Age	Relationship to child/adolescent

Custody status: _____

Frequency of contact with non-custodial parent: _____

Is your child/adolescent experiencing any problems in their relationships with:

___ Child care providers ___ Siblings ___ Stepfather ___ Step siblings
___ Father ___ Mother ___ Stepmother ___ Neighbors
___ Friends/Peers ___ Other ___ None of the above

Comments: _____

Has your child/adolescent ever had any involvement with the legal system? _____

_____

Are there any legal problems having to do with other family members? _____

_____

What does your child/adolescent do for fun or relaxation? _____

_____

Are there cultural/ethnic or religious issues that you would like me to be aware of?

_____

_____

Client Signature _____ Date _____

Clinician Signature _____ Date _____