CHILD/ADOLECENT INITIAL ASSESSMENT

Date _____

Child's Name _____ **Sex: M F SSN #:** _____

Address _____ **Date of Birth** _____ **Age** _____

City _____ **Zip Code** _____ **Phone** _____

Parent(s)/Guardian(s) _____

Email Address _____ **Alternate Phone** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Who lives in the home at the current time? (name, age, relationship) _____

_____

_____

_____

Reason for seeking counseling _____

_____

_____

_____

Has the child had previous counseling? ☐ Yes ☐ No ☐ Only as part of family

Where? _____ When _____

Was it helpful? _____

_____

_____

Has the child had previous substance abuse treatment? ☐ Yes ☐ No ☐ Only as part of family

Where? _____ When _____

Was it helpful? _____

_____

_____

EDUCATIONAL HISTORY

School _____ **Grade** _____ **Teacher** _____

School Counselor/Social Worker _____

Has the child ever been diagnosed? ☐ Learning disability ☐ ADHD ☐ Sensory Integrative ☐ Autism ☐ Oppositional Defiant ☐ Emotionally Impaired ☐ Physical Impairment ☐ Pervasive Developmental Dis.

Describe the child's academic performance: _____

_____

Does the child struggle with distractibility? ☐ Yes ☐ No ☐ School thinks so, I'm not sure ☐ Sometimes

Has the child struggled with any of the following? ☐ Truancy ☐ Suspension ☐ Fighting ☐ Vandalism ☐ Expulsion ☐ Defiance ☐ School refusal ☐ Threatening behaviors ☐ Weapons ☐ Separated from parent(s)

What does the child do well at school? _____

Has the child ever been held back? ☐ No ☐ Yes, when? _____

LEGAL SYSTEM INVOLVEMENT

Has the child been involved with the legal system? ☐ Yes, in the past ☐ Currently ☐ No

If so, please explain _____

_____

Is the child on probation? ☐ No ☐ Yes, probation officer _____

FAMILY HISTORY

Does anyone in the extended family unit have a history of alcoholism? ☐ No ☐ Yes, please explain

_____

Drug abuse? ☐ No ☐ Yes, please explain _____

Depression? ☐ No ☐ Yes, please explain _____

Anxiety? ☐ No ☐ Yes, please explain

_____

Mental Illness? ☐ No ☐ Yes, please explain _____

Other Addictions? ☐ No ☐ Yes, please explain _____

Has the child ever been abused? ☐ No ☐ Yes, ☐ Physical ☐ Emotional ☐ Sexual ☐ Spiritual ☐ Verbal

Explain _____

HEALTH HISTORY

Where was the child born? _____

Adopted? ☐ No ☐ Yes, at age _____

Explain any complications the mother had during pregnancy or labor _____

_____

Child's physician/pediatrician _____

_____

Please list current or past medical conditions _____

_____

_____

Please list any hospitalizations and surgeries _____

_____

_____

Please list current or past medications _____

_____

_____

_____

Please list current allergies _____

_____

Has the child ever had a seizure? ☐ No ☐ Yes, specify _____

Has the child ever had a head injury? ☐ No ☐ Yes, specify _____

Does the child complain of frequent headaches? ☐ No ☐ Yes, specify _____

Does the child complain of dizziness? ☐ No ☐ Yes, specify _____

Does the child have current difficulties with wetting/soiling? ☐ No ☐ Yes, specify _____

_____

Does the child have adequate personal hygiene habits? ☐ No ☐ Yes

At what age did the child walk _____ **talk** _____ **complete toilet training** _____

Eating Habits? ☐ No Change ☐ Not Eating ☐ Over-Eating ☐ Significant Weight Change ____lbs.

☐ Selective Eating Habits _____

☐ Other _____

Sleeping Habits? ☐ No Change ☐ Trouble Getting to Sleep ☐ Trouble Staying Asleep ☐ Early Waking

☐ Sleepwalking ☐ Nightmares/terrors ☐ Other _____

HARMFUL BEHAVIORS

Are you concerned about suicidal statements or gestures with the child? ☐ No ☐ Yes, explain _____

_____ ☐ Prior Attempt, explain _____

Are you concerned about the child seriously injuring others? ☐ No ☐ Yes, explain _____

_____ ☐ Prior Attempt, explain _____

Other risk/safety factors _____

_____

PERSONALITY

Does the child form friendships easily? ☐ Yes ☐ No ☐ Only in small crowds

Does the child struggle with any of the following? ☐ "Late Bloomer" ☐ Bullying ☐ Easy Target

☐ Extremely Shy ☐ Needs Social Reassurance ☐ Other _____

Who is the child's best friend at the current time? _____

What does the child do well socially? _____

_____

_____

What are some of the child's favorite activities/toys? _____

_____

_____

_____

Is the child a part of any group or organization? ☐ No ☐ Yes

If yes, what? _____

Cultural Heritage _____

SPIRITUALITY

Is your family affiliated with a church? ☐ No ☐ Yes, where? _____

Who is the minister/reverend? _____

How often do you attend? ☐ Regularly ☐ Sporadically ☐ Holidays ☐ Never

Is the child involved in a church youth group? ☐ No ☐ Yes ☐ Sometimes

PREPARATION FOR COUNSELING

Have you spoken with the child about why he/she is coming to counseling? ☐ No ☐ Yes

What is the last major change in the child's life? _____

_____

Has the child ever experienced a traumatic event? ☐ No ☐ Yes, explain _____

Is there anything else that the therapist should know about the child? _____

Is there anyone else who should be invited into the counseling process with the child? ☐ No ☐ Yes,

Whom _____

Comments _____

TREATMENT PLANNING

What would you like to see occur from counseling services for the child? _____

How frequently would you like the child's counseling sessions to be scheduled?

☐ as needed ☐ 1x/month ☐ 2x/month ☐ 3x/month ☐ 4x/month ☐ don't know yet

Is everyone in the child's family aware of the concerns? ☐ Yes ☐ No

Is everyone in the family willing to participate in counseling? ☐ Yes ☐ No ☐ Don't know

Is there anything else the child's counselor should know? _____