More MH Counseling
Make More Happen

Child/Adolescent Assessment

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Child's Name:_____ Today's Date:_____

Child Residence: _____

Child's age:_____ Date of Birth (DOB):_____

Cell phone:_____ May I leave a message? Yes No

Address:_____

_____

Parent/Legal Guardian: _____ Parent/Legal Guardian: _____

Address: _____ Address: _____

Phone:_____ Phone: _____

Email: _____ (E-mail not considered a confidential medium of communication)

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

_____

_____

_____

What are your hopes regarding your child's therapy?_____

_____

_____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? _____

_____

_____

Has your child ever been treated for any of the following? If so please circle and describe:
Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Please list your child's current prescription medications with dosage (psychiatric and general health):

Please list any previous psychiatric medications (with dosage and dates): _____

Do you suspect your know your child drinks alcohol or uses recreational drugs? If so, what kind & how often?

Do you or anyone close to your child consider his/her use to be a problem? Yes No

Who is your child's primary care physician? _____

Who is your child's psychiatrist (if applicable)? _____

When was your child's last complete physical exam (mo/year)? _____

How many times a week does your child exercise? _____What type & how many minutes? _____

What types of food does he/she often eat? _____

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	**BIOLOGICAL FATHER**
Current age, or If deceased date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual		

Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:__

_____

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

Name	Bio, Step, Adopted	Age	School Grade	Gender M/F	Lives with you? Y/N	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	

Alcoholism	Yes	No
Substance Abuse	Yes	No
Domestic Violence	Yes	No
Eating Disorders	Yes	No
Obesity	Yes	No
Schizophrenia	Yes	No
Counseling or Psychotherapy	Yes	No
Psychiatric Hospitalizations	Yes	No

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

_____

Medications used during pregnancy? Please list: _____

Smoking? Yes No How much? _____

Alcohol intake? Yes No How much? _____

Drug intake? Yes No How much? _____

Length of pregnancy?_____Weeks Age of mother at birth: _____ Birth weight: _____

Were there any complications during delivery? If so, please describe: _____

_____

Length of stay in the hospital? Mother: _____(days) Child: _____(days)

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____ Crawl _____ Stand Alone_____ Walk Alone _____

First Words_____ First Phrases_____

Toilet trained? Yes No If yes, days?_____Nights? _____

Has your child wet or soiled himself after being trained? Yes No If yes, until what age?_____

Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain:_____

_____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____Public or Private (circle one)?

Street Address: _____

School District/County? _____ Phone: ___(____)_____

What preschool experience did your child have? _____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain:

_____

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

Has your child ever received tutoring? Yes No If so, please explain: _____

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? Yes No Please explain: _____

_____

Home/Family Life

What are 5 things that you enjoy most about your child? _____

_____

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith based group? _____

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? _____

_____

What are your strengths personally and as a parent? _____

What are some of your areas of needed growth? _____

What are your child's strengths (things he/she is good at)? _____

What are your child's areas of needed growth? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your child get along with other children? _____

Who are some of your child's closest friends (first name) _____

_____

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5

Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Sub Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No
(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe: _____

_____

_____

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child: _____

_____

_____

Clinical Impression 1: _____
Clinical Impression 2: _____
Clinical Impression 3: _____
Clinical Impression 4: _____

Additional Information: _____

_____

_____

Clinician Signature: _____
Date: _____