

CHILD/ADOLESCENT PSYCHOSOCIAL ASSESSMENT

Date of appointment: _____ Time of appointment: _____

Client Name: _____ Age: _____ DOB: _____

Gender: Male Female Transgender Preferred Name/Nickname: _____

Ethnicity: Hispanic Non-Hispanic Race: _____

Name of Person completing form: _____

Relationship to client: _____

PRESENTING PROBLEM: (Briefly describe the issues/problems which led to your decision to seek therapy services).

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

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

PRESENTING PROBLEM CATEGORIZATION: (Please check all that apply and circle the description of symptom)

Symptoms causing concern, distress or impairment:

Change in sleep patterns (please circle): sleeping more sleeping less
difficulty falling asleep difficulty staying asleep difficulty waking up difficulty staying awake

Concentration: Decreased concentration Increased or excessive concentration

Change in appetite: Increased appetite Decreased appetite

Increased Anxiety (describe): _____

Mood Swings (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: _____

Other (Please describe other concerns): _____

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

One week One month 1 – 6 Months 6 Months – 1 Year Longer than one 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

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 Partnership

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 With Child <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

What else do you feel/believe would be helpful, or important for us 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? _____

Other Losses: _____

Additional information (if needed):

PREGNANCY & BIRTH HISTORY:

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

Full-term Birth Premature Birth

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

Were drugs or alcohol consumed during pregnancy? Yes No

Child's weight at birth? _____ lbs. _____ oz. Child's health at birth? _____

Length of hospital stay? _____ Post-partum depression? Yes No

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

Domestic adoption International adoption (Country: _____)

DEVELOPMENTAL HISTORY:

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 have any recurrent medical conditions such as ear infections, asthma or allergies? Yes No

If yes, please explain: _____

Does your child have tubes in his/her ears? Yes No

Include current significant medical problems, physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc.)

Medical Conditions	Currently receiving treatment?	Provider	Does this condition cause stress or impairment at this time?	What have you found that helps?

Does your child take any medications? Yes No

Please list medications (including psychotropic, over-the-counter, herbal remedies) that you have taken in the past 6 months

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

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 in the chart below.

Reason for Previous Hospitalizations, Accident, Illness	Date/Location of Hospitalization

Has your child had the following screenings (please check all that apply)?

Hearing Screening Date: _____ Outcome: _____

Vision Screening Date: _____ Outcome: _____

Speech/Language Screening Date: _____ Outcome: _____

Primary Care Doctor: _____ Facility: _____ Phone Number: _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Is your child currently being seen by a counselor? Yes No

If yes, name of current counselor _____ Length of Treatment _____

Is your child currently being seen by a psychiatrist? Yes No

If yes, name of current psychiatrist _____ Length of Treatment _____

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 received counseling services or been hospitalized for mental health or drug and alcohol concerns in the past? Yes No

If yes, please list previous counseling/hospitalizations for mental health/drug and alcohol concerns below

Dates of Service	Place/Provider	Reason for treatment	Were the services helpful

Additional information: _____

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)

CURRENT FUNCTIONING:

Do you have concerns about your child in the following areas? (check all that apply)?

Eating Hygiene/grooming Sleeping Activities/play Social Relationships

If so, please describe: _____

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 7 by placing a check above the number that best describes your child):

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

CAN sit still and listen
for long periods of time

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

CAN'T sit still and listen
for long periods of time

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

ENJOYS ROUTINE; easily
upset when day doesn't
go as usual

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

**ENJOYS DOING THINGS
DIFFERENTLY;** may not
notice small changes in
the day

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

ANXIOUS-usually
frustrated and worried

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

HAPPY-usually enjoys
what he/she is doing

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

CURIOUS-usually eager
to know something

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

ANGRY-easily frustrated
and annoyed with others

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

CALM-usually relaxed

SAD-usually unhappy;
hard time having fun

TIMID-usually not
interested

CALM-usually
composed and
peaceful with others

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

MILD REACTION-calm
and cooperative; Easily
pushed around by others

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

STRONG REACTION-
may cry or yell over
small things

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

Will stick with something
until it is done

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

Gives up on tasks;
has trouble finishing
things

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

Learns by seeing
touching and using all
his/her senses

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

Has strong reaction to
noise, lights, hugging
or touching

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

Sympathetic to others;
can use words to tell
how he/she feels

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

Unaware of the
feelings of others

ADAPTABILITY (How easily does my child accept changes?)

Often fearful with new people and new situations

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

Will easily meet and accept new people and activities

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

Stays focused on tasks until completed

____: ____: ____: ____: ____: ____: ____
1 2 3 4 5 6 7

Easily sidetracked; difficulty following directions

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? _____

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)? (circle ALL that apply)

- Attending regularly Home-schooled Some truancy Alternative school Suspended
Expelled Dropped Out GED program

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: _____

EMPLOYMENT:

Is your child currently employed? Yes No

If employed, where are they working? _____ How long? _____

Does your child enjoy their current job? Yes No

HOUSING:

Would you consider your housing to be: stable unstable If unstable, please describe: _____

Please choose the one that best describes the current housing arrangement for this child:

- Parent/Guardian owns home
- Parent/Guardian rents home
- Child and family live with relatives/friends (temporary)
- Child and family live with relatives/friends (permanent)
- Homeless Transitional Housing Emergency Shelter

How long has this child lived in the current living situation? _____

How many times has the child moved in the past two years? _____

What else do you think is important for us to understand about your housing/living situation?

FOSTER CARE INVOLVEMENT:

Has your child ever been in foster care? Yes No Unknown

From _____ age to _____ age Reason: _____

Type of Placement: Familial Placement Non-Familial Placement

Current Status: In-Care Out of Care

If Out of Care, reason for leaving: Adopted Returned to Home Emancipated

Ran away from care Other: _____

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.

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Self										
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										
Paternal Aunt										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Biological Child										

Additional Information: _____

ALCOHOL/DRUG ASSESSMENT:

Does your child use tobacco or smokeless tobacco? Yes No Do not know

Does your child use alcohol or drugs? Yes No Do not know

To your knowledge, has your child ever used medications (prescriptions drugs or over the counter medication) recreationally? Yes No Do not know

To your knowledge, has your child ever overdosed or passed out on alcohol or other drugs?

Yes No If yes, when was the last overdose? _____

Has your child ever experienced problems related to their alcohol use? Yes No

If yes, please check area and describe problems:

Legal Social/Peer Work Family Friends Financial

Please describe: _____

If yes, have they continued to drink/use drugs? Yes No

LEGAL INVOLVEMENT:

Is there a current custody case involving your child? Yes No If yes, please describe below.

History of CPS involvement: None Past Current Please describe below.

Please indicate by checking your child's legal status below.

No Involvement No Involvement Probation | Length: _____

Parole | Length: _____ Charges Pending Prior Incarceration

Law Suit or other Court Proceeding

Charges: _____ Probation/Parole Officer's Name: _____

Contact #: _____

Additional Information: _____

HISTORY OF ABUSE/NEGLECT:

Has your child ever been abused or assaulted? Yes No If Yes, please complete the chart below.

Type of Abuse	By Whom? (relation to child if any)	At What Age?	Was it Reported?
<input type="checkbox"/> Sexual			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Emotional			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Verbal			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Abandoned/Neglected			<input type="checkbox"/> Yes <input type="checkbox"/> No

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 us to know?

HISTORY OF VIOLENCE:

Has your child ever been accused of abusing or assaulting someone? Yes No If yes, please complete chart below.

Type of Abuse	To Whom?	Age of your child?	Was it Reported?
<input type="checkbox"/> Sexual			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Emotional			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Verbal			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Abandoned/Neglected			<input type="checkbox"/> Yes <input type="checkbox"/> No

Has your child ever been known to bully other children? Yes No

What else do you feel/believe is important for us to know? _____

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: _____

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 us 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 _____