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CHILD INITIAL CLINICAL ASSESSMENT FORM

Date:_____Child's Full Name:_____ Sex: _____

Child's Nickname/Preferred Name, if applicable: _____

Age: _____Date of Birth: _____Grade: _____School: _____

Home Address: _____

Home/ Cell Phone: _____Okay to leave message? □ Yes □ No

Parent/Guardian #1 Name: _____Email_____

Cell Phone: _____ Okay to leave message? □ Yes □ No
Does child live with this parent: □ Yes □ No

Parent/Guardian's Occupation/Employer: _____

Parent/Guardian #2 Name: _____Email_____

Cell Phone: _____ Okay to leave message? □ Yes □ No
Does child live with this parent: □ Yes □ No

Parent/Guardian's Occupation/Employer: _____

Marital status of Parents: ___ Single ___ Married ____ Divorced ____ Widowed
____ Domestic Partnership

Emergency Contact Information: Name: _____ Relationship: _____

Primary phone number: _____

Pediatrician: _____Pediatrician's phone number: _____

Presenting Problem: Briefly describe the problems/concerns:

_____

_____

_____

Household members, age and relationship:

_____

_____

_____

_____

_____

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?

_____

_____

_____

Developmental Milestones:
(Please note whether it was achieved early, late or within normal limits)

Rolled over
□ Early □ Normal □ Late

Sat without support
□ Early □ Normal □ Late

Crawled
□ Early □ Normal □ Late

Grasped pencil/crayon
□ Early □ Normal □ Late

Stood up
□ Early □ Normal □ Late

Fed self
□ Early □ Normal □ Late

Walked
□ Early □ Normal □ Late

Spoke first words
□ Early □ Normal □ Late

Sleep: What time does your child go to sleep? _____ What time does your child wake up? _____

Please briefly describe your child's nightly sleep routine:

_____

_____

Does your child sleep in his/her own room? □ Yes □ No
If yes, at what age did your child begin to sleep alone? _____

(Please check the following items that relate to your child's sleep):
□ Difficulty staying asleep □ Difficulty falling asleep □ Frequent wakening □ Sleep walking
□ Night sweats □ Nightmares □ Enuresis (urinating on oneself) □ Encopresis (the soiling of the underwear) □ Recurrent nightmares

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: _____

_____

RECENT LOSSES:
Family Member ____ Friend _____ Health _____ Job ____ Housing _____ None _____

Who? _____ When? _____

Nature of Loss? _____

Other Losses: _____

_____

_____

Behavior:
(Please check any of the following items that seem to accurately describe your child's personality or behavior):

□ Shy	□ Immature	□ Well-behaved
□ Stubborn	□ Impulsive	□ Temper-tantrums
□ Cries easily	□ Cries excessively	□ Tells lies
□ Thumb-sucking	□ Head-banging	□ Tics and Twitching
□ Always in motion	□ Excessively fidgety	□ Difficulty paying attention
□ Difficulty with transitions	□ Difficulty finishing a task	□ Disorganized
□ Forgetful	□ Angry	□ Gets easily frustrated
□ Has poor self-esteem	□ Fears making mistakes	□ Harm to animals

□ Willing to try new activities □ Attentive □ Destructive/aggressive
□ Fears of looking "stupid" □ Moods change quickly □ Cooperative
□ Impulsive □ Sees things that are not there □ Hears voices that are not there
□ Engages in risky behavior □ Lacks judgment □ Uses drugs
□ Drinks alcohol □ Skips school/classes □ Refuses to go to school
□ Difficulty sharing □ Difficulty listening □ Difficulty understanding jokes
□ Self-abusive behavior □ Withdrawn □ Argumentative
□ Poor awareness of time □ Gets lost easily □ Becomes frightened easily
□ Frequent Accidents □ Steals things □ Blames others
□ Failure to take responsibility for actions □ Seems unable to empathize with others
□ Difficulty separating from caregiver □ Gets distracted while watching television
□ Moods seem to be connected with the seasons □ Difficulty making or keeping eye contact
□ Plays alone for a reasonable length of time □ Avoids being the center of attention
□ Difficulty staying at one task for a long period of time
□ Rigid/Inflexible/unwilling to try new activities or new ways of doing things

Compulsions (please list): _____

Obsessions (please list): _____

Fears (please list): _____

Currently Suicidal □ Yes □ No Has child been suicidal in the past? □ Yes □ No (If yes, please explain nature of ideation or attempt):

_____

_____

Homicidal (If yes, please explain nature of ideation or attempt):

_____

_____

Has your child ever inflicted burns or wound on his/herself? ____ Yes ____ No If so, please explain:

_____

_____

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:

_____

_____

_____

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.

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

Do they know they were adopted? _____ If so, at what age were they told? _____

How did they react to the news? _____

Current Medications:

Name: _____Dose: _____

Reason Prescribed: _____

Name: _____Dose: _____

Reason Prescribed: _____

Name: _____Dose: _____

Reason Prescribed: _____

Medical Hospitalizations client has had in the past? (Surgeries, Illness, accidents, etc.):

Reason	**Date**
_____	_____
_____	_____
_____	_____

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:

_____

_____

_____

Education:

Please check any of the following problems reported by your child's school or teacher:

□ Reading	□ Writing	□ Math
□ Behavior	□ Social Adjustment	□ Attention Span
□ Spelling	□ Distractibility	□ Hyperactivity
□ Following Directions	□ Getting along with other children	
□ Getting along with teachers	□ Does not complete homework readily	

Please describe your child's attitude towards school:

_____

_____

Has your child ever missed an extended amount of school?

If so, please explain:

_____

_____

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: _____

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 ・ 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?

_____

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

Family Mental Health History:

In the section below identify if there is a family history or if you have any issues with any of the following. If yes, please indicate the family member's relationship to you (father, maternal grandmother, paternal uncle, etc.).

Alcohol/Substance Abuse: yes/no _____

Anxiety: yes/no _____

Depression: yes/no _____

Bipolar Disorder: yes / no _____

Domestic Violence: yes/no _____

Eating Disorders: yes/no _____

Obesity: yes/no _____

Obsessive Compulsive Behavior: yes/no _____

Schizophrenia: yes/no _____

Suicide Attempts: yes/no _____

Homicide or Attempts: yes / no _____

Sexual Abuse of client or other family members: yes / no _____

_____

Social and Emotional Development:

Describe your child's current social skills and peer relationships:

_____

_____

Please note if your child has a history of being bullied/teased or has been aggressive in play with others:

_____

_____

How would you describe your child socially? How do you think your child interacts with peers while at school?

_____

_____

Does your child have difficulty keeping friends?

_____

Does your child have a best friend? If so, how often do they interact at home or away from school?

_____

_____

Please list your child's favorite hobbies, activities, and games, other than sports (e.g. piano, books, dolls, crafts, cars, etc.). Please describe how well you feel your child does in these areas:

_____

_____

_____

Which sports does your child most enjoy playing? Describe how well your child does in these sports compared to peers: _____

_____

_____

Please list any additional organizations, clubs, teams, or groups in which your child participates:

_____

_____

_____

How does your child handle stress?

_____

_____

What are your child's strengths?

_____

_____

In what areas would you like to see your child stronger?

_____

_____

Is there any other pertinent information that you would like to share?

_____

_____

Form completed by: _____Relationship to child: _____

Therapist: _____ Date: _____

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 / DSS 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: _____

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?

Strengths, Needs, Abilities and Preferences:

Strengths: (Family, social, spiritual & hobbies that have helped overcome past crises):

Needs: (Client's expression of current needs: emotional, physical & environmental):

Abilities: Client's ability to follow up with treatment _____(yes/no), Client understands instructions & is willing to participate in treatment _____(yes/no).

Preferences: Appointment day/evening (circle).

Are you currently seeking treatment from another provider: Yes/No

MENTAL STATUS				
Affect	☐ Appropriate	☐ Blunted	☐ Constricted	☐ Flat ☐ Labile

Appearance	☐ Well-groomed	☐ Disheveled	☐ Inappropriate	
Attitude	☐ Cooperative	☐ Guarded	☐ Uncooperative	
Mood	☐ Euthymic	☐ Depressed	☐ Anxious	☐ Euphoric
Motor Activity	☐ Calm	☐ Hyperactive	☐ Agitated	☐ Tremors/Tics
Thought Process	☐ Intact	☐ Circumstantial	☐ Tangential	☐ Loose assoc.
Thought Content	☐ Appropriate	☐ Hallucinations	☐ Delusions	
Orientation	☐ Fully oriented	Disoriented as to: ☐ Time ☐ Place ☐ Person		

Diagnosis:

_____

_____

_____

Criteria for Diagnosis:

_____ _____

_____ _____

_____ _____

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: _____