CHILD/ADOLESCENT ASSESSMENT FORM

Date: _____

Name of Child/Adolescent: _____ Date of Birth: _____

CURRENT SITUATION:

What concern brings you here: (How long has this been a problem?)
(What have you done, or are you doing, to resolve this problem?)

_____
_____
_____
_____
_____
_____

What do you hope to accomplish in this session/in therapy?

_____
_____
_____

DEVELOPMENTAL HISTORY:

PRENATAL/BIRTH HISTORY:

Health of mother: ☐ Good ☐ Fair ☐ Poor ☐ Do not know

Did the mother use any of the following during pregnancy?

☐ Alcohol ☐ Marijuana/Cocaine/Crack

☐ Cigarettes ☐ Prescription Drugs (list):

_____

☐ Coffee/Caffeine Drinks ☐ None of the above ☐ Do not know

Any medical complications during pregnancy? ☐ Yes ☐ No

Comments:

_____
_____

CHILD/ADOLESCENT ASSESSMENT:

Length of Pregnancy in months or weeks if known: _____ Birth Weight _____

Were there any complications during or following birth? (Check all that apply)

☐ Baby given oxygen	☐ Incubator	☐ Rashes
☐ Baby on heart monitor	☐ Jaundice	☐ Very active
☐ Birth defects	☐ Problems breathing	☐ Very quiet
☐ Blood transfusions (baby)	☐ Problems eating/digestion	☐ Other_____
☐ Delivery aided by instrument	☐ Problems sucking	☐ None of the above
☐ Delivery by cesarean section		

EARLY DEVELOPMENT:

Your child's/adolescent's approximate age when he/she began:

walking at _____ months; talking (single words) at _____ years; talking (short sentences-2+ words) at _____ years; toilet training: daytime at _____ years and nighttime at _____ years.

Overall, you feel your child/adolescent developed at the following rate: ☐ Slow ☐ Normal ☐ Rapid

Comments:

_____

_____

During the first three years of life, your child frequently exhibited: (Check all that apply)

☐ Accident prone behavior	☐ Feeding problems	☐ Restless behavior
☐ Avoidance of cuddling	☐ Head banging	☐ Self-hurting behavior
☐ Colic	☐ Lack of coordination	☐ Temper tantrums
☐ Destructive behavior	☐ Overactive behavior	☐ Unresponsive to discipline
☐ Distractibility	☐ Withdrawn behavior	☐ None of the above
☐ Extreme mood changes	☐ Problems with sleeping/waking patterns	

Comments:

_____

_____

SEXUALITY:

Is your child/adolescent: ☐ Prepubescent ☐ Pubescent

For females, menstruation began at ____(age)

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's/adolescent's sexual development or sexual orientation?
☐ Yes ☐ No

Comments:

_____

_____

SIGNIFICANT EVENTS:

- □ Change of school
- □ Death in family
- □ Divorce or separation
- □ Frightening experience for child/adolescent
- □ Loss of someone close to child/adolescent
- □ Move to a new place
- □ Serious illness or injury to family member/friend
- □ Other
- □ None of the above

Comments:

_____

_____

HEALTH/MEDICAL HISTORY:

Primary Care Physician/Pediatrician

_____

Current: Height _____ Weight _____

Does your child/adolescent have any drug/food allergies? □ Yes □ No
If yes, please specify:

_____

_____

Are childhood immunizations up to date? □ Yes □ No □ Do not know

Does your child/adolescent have an eating or sleeping problem? (Check all that apply)

- □ Dieting
- □ Overeats
- □ Picky eater
- □ Recent weight gain
- □ Recent weight loss
- □ Refuses to eat
- □ Vomiting
- □ Bedwetting
- □ Difficulty falling asleep
- □ Does not want to sleep alone
- □ Nightmares
- □ Sleeps too much
- □ Soiling
- □ Trouble staying asleep
- □ Very restless at night
- □ Other _____
- □ None of the above

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

□ Good □ Fair □ Poor

Has your child/adolescent been diagnosed and/or currently being treated for any of the following?
(Check all that apply)

- □ ADHD
- □ Anemia
- □ Asthma
- □ Cancer/Leukemia
- □ Cerebral Palsy
- □ Diabetes
- □ Ear Infections
- □ Encephalitis
- □ Epilepsy
- □ Fever above 105 degrees F
- □ Hearing problems
- □ Heart problems
- □ HIV/AIDS
- □ Hydrocephalus
- □ Lead Poisoning
- □ Loss of consciousness
- □ Meningitis
- □ Mental Retardation
- □ Musculo-Skeletal Condition
- □ Seizures
- □ Vision problems
- □ Other_____
- □ None of the above

Comments:

_____

_____

Has your child/adolescent had any surgeries/accidents/conditions requiring hospitalization or same day surgery?
□ Yes □ No
If yes: Date: _____ Conditions: _____
_____ _____
_____ _____

Is your child/adolescent taking any medication? (Prescription and over-the-counter) □ Yes □ No
List medication/purpose: _____ _____
_____
_____

BEHAVIORAL HEALTH HISTORY:

Has your child/adolescent had prior mental health services, counseling and/or alcohol/drug treatment? □ Yes □ No

OUTPATIENT		INPATIENT	
Therapist/Program	Date	Hospital	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child/adolescent: (Check all that apply)
- □ Physically harmed another individual, pet or small animal?
- □ Received medication in the past for emotional, learning, behavioral problems?
- □ Run away from home?
- □ Started a fire?
- □ Talked about or attempted suicide?
- □ Threatened to physically harm anyone?
- □ None of the above

Comments:
_____
_____

Has your child/adolescent ever experienced or witnessed:
- □ Domestic violence
- □ Emotional abuse
- □ Physical abuse
- □ Rape/sexual assault
- □ Sexual abuse
- □ Other significant trauma
- □ None of the above

Comments:
_____
_____

CULTURAL/ETHNIC/SPIRITUAL:

Cultural/ethnic/racial issues that need consideration:
_____
_____

Religious/spiritual issues that need consideration:
_____
_____

ACTIVITIES OF DAILY LIVING:

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

- □ Adapting to changes
- □ Attending to tasks
- □ Decision making
- □ Following a routine
- □ Other _____
- □ Goal setting
- □ Learning
- □ Performing self-care (hygiene, grooming, bathing, etc.)
- □ Problem Solving
- □ None of the above

Comments:

_____
_____

EDUCATION:

School presently attending: _____ Grade _____

School related issues: (Check all that apply)

- □ Academic problems
- □ Advanced a grade
- □ Attendance
- □ Behavior
- □ Detention
- □ Held back a grade
- □ Homework
- □ Met with school counselor
- □ Peer relationships
- □ Relationship with teacher(s)
- □ Required special help
- □ Suspension/expulsion
- □ Transportation
- □ None of the above
- □ Tested by school psychologist (ADD, ADHD, other)

Comments:

_____
_____

FAMILY HISTORY:

List all the people who are currently living in the household:

Name	Age	Relationship to child/adolescent

List sibling(s) not living in the household:

Name	Age	Relationship to child/adolescent

FAMILY HISTORY (cont.):

Custody Status: □ Birth Parents □ Adopted: Age of adoption _____
□ Mother only □ Father only
□ Joint Custody □ Ward of the court
□ Other relative – Please specify: _____

Frequency of contact between non-custodial/residential parent and your child/adolescent:
_____
_____

Is your child/adolescent experiencing any problems in relationships with: (Check all that apply)
□ Child care providers □ Siblings □ Stepfather □ Step-siblings
□ Father □ Mother □ Stepmother □ Other
□ None of the above
Comments:
_____
_____

Have any family members had problems with substance abuse (drugs, alcohol) or with mental/emotional problems?
□ Yes □ No
Comments:
_____
_____

ALCOHOL AND DRUG:

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

LEGAL:

Has your child/adolescent ever had involvement with the legal system? □ Yes □ No
Are there any legal problems having to do with other family members? □ Yes □ No
Comments:
_____
_____

_____ _____
Parent/Guardian Signature-Completing the Form Date

_____ _____
Signature of CCPC-Ohio Therapist Date

_____ _____
Reviewed/Updated Date