Joyful Family Therapy, LLC

Behavioral Health Assessment

Child/Adolescent Initial Assessment Form

Client's First Name: _____ Last Name: _____

Address:_____City:_____State:_____Zip:_____

Teen's mobile: _____ May we leave a message? □Yes □No

Home Phone: _____ May we leave a message? □Yes □No

Names of parents/guardians:

Mother Name:
First_____Middle:_____Last:_____

Address:_____City:_____State:____Zip:_____

Email:_____Mobile:_____

May we email you? □Yes □No *Please note: Email is not considered to be a confidential form of communication.

Father Name:
First_____Middle:_____Last:_____

Address:_____City:_____State:____Zip:_____

Email:_____Mobile:_____

May we email you? □Yes □No *Please note: Email is not considered to be a confidential form of communication.

Parents: □ Married □ Separated □ Divorced

If divorced, what is legal custody
arrangement?_____

Child's Birth Date:_____ Age: _____ Gender: □ Male □ Female

School:_____Grade:_____

Pediatrician:_____Phone:_____

Psychiatrist (if any):_____Phone:_____

Siblings:

Name:_____Age:_____Grade

Name:_____Age:_____Grade

Name:_____Age:_____Grade

Please list the reasons you are seeking counseling:

_____

_____

Referred by (if any):

_____

COUNSELING AND/OR PSYCHIATRIC HISTORY

Has your child or family previously received any type of mental health services?

□ No □ Yes,

If yes, briefly describe the
experience:_____

_____

Is your child currently taking any prescription medication? □ No □ Yes If yes,

Please list, include dosage and dates:

_____

_____

Has your child ever been prescribed psychiatric medication? □ No □ Yes

If yes, please list, provide reasons and dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any health concerns:_____

2. How would you rate your child's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please describe:_____

3. What types of physical exercise does your child get?

_____

_____How often per week?_____

4. Please list any difficulties your child might be experiencing with appetite or eating patterns._____

5. Is your child currently experiencing overwhelming sadness or depression? □ No □ Yes

If yes, please describe, noting dates/duration:

_____

_____

6. Has your child ever, or is he/she currently, experiencing self-harming thoughts?

□ No □ Yes If yes, please describe, noting dates/duration:_____

_____

7. Is your child currently experiencing anxiety, panic attacks or phobias? □ No □ Yes

If yes, please describe, noting dates/duration:_____

_____

8. Describe any changes or stressful events your child may have experienced recently:

_____

_____

9. Describe any trauma history that your child may have experienced:_____

_____

What are your/child goals for therapy? Please list at least three goals

1. _____
2. _____
3. _____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following:

Please Circle List Family Member

Alcohol/Substance Abuse yes/no……

Anxiety yes/no……

Depression yes/no……

Domestic Violence yes/no……

Eating Disorders yes/no……

Obesity yes/no……

Obsessive Compulsive Behavior yes/no……

Schizophrenia yes/no……

Bipolar Disorder yes/no……

Suicide Attempts yes/no……

ADDITIONAL INFORMATION

1. Briefly describe your child's academic strengths and challenges:_____

_____

_____

2. Briefly describe your child's social functioning, noting any concerns you may have:

_____

3. Do you consider your family and/or your child to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:_____

4. What do you consider to be some of your child's strengths and weaknesses?

_____

_____

5. Please describe any concerns with family relationships:_____

_____

6. Please describe how discipline is handled in your family (for example, time outs, loss of privileges) and any concerns you may have related to discipline:_____

_____

Joyful Family Therapy, LLC: Informed Consent

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

 Duty to Warn and Protect When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

 Abuse/Neglect of Children and Vulnerable Adults If the therapist becomes aware during the course of treatment of any abuse/neglect or danger of abuse/neglect to a child (or vulnerable adult), then the counselor is required to report this information to the appropriate social service and/or legal authorities.

 Minors/Guardianship Parents/legal guardians of non-emancipated minors have the right to access records.

 Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Parent/guardian signature: _____ Date: _____

AUTHORIZATION TO TREAT MINORS

I/we, _____ (name of parents/guardians), give my/our permission to Joyful Family Therapy, LLC to provide services to my/our child custodian, _____ (name of minor child), for therapy with or without me being present in the same session. I/we understand that we are the holder of confidential privilege. However, in the interest of developing a trusting relationship between the therapist and my/our child, I/we give the therapist permission to reveal or withhold information that in his/her clinical judgment is necessary to best help and treat my/our child.

Parent/guardian signature_____ Date _____

Youth signature_____ Date: _____

CONSENT TO TREAT

Please sign below to indicate that you have read ALL the above policies and that you understand and agree to comply with them. Your signature indicates that you have had a chance to ask your therapist any questions you might have about these policies and that your questions have been answered satisfactorily. You agree that you are personally responsible for all financial obligations incurred.

Signature parent/guardian _____Date:_____