



Carolina Counseling Services

Child/Adolescent Comprehensive Clinical Assessment

***** If there are any custody issues involving this child, please see one of our office staff immediately so that we may refer you to a therapist who specializes in those issues. Currently, none of our therapists will be able to assist you. We apologize for any inconvenience*****

Medical History

Name _____ Date of Birth _____ Age _____ Gender ____ M ____ F

Name of Primary Care Physician _____

Physician's Address _____ Physician's Phone _____

Date of Last Medical Examination _____ Date of Next Appointment _____

What Previous Therapy has this child had? Please describe _____

Family History

Please check all the information which applies to your child's biological parents:

MOTHER: ____ living	FATHER: ____ living
____ deceased	____ deceased
____ married	____ married
____ divorced	____ divorced
____ living with someone	____ living with someone
____ remarried ____ # of times	____ remarried ____ # of times

With whom does the child live: _____

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse _____

Sexual/Physical/Emotional abuse _____

Please check any of the following that describe how you believe your child has been feeling lately:

____ sad ____ anxious ____ depressed ____ frightened ____ guilty ____ angry ____ ashamed ____ aggressive ____ resentful ____ worthless
____ tearful ____ irritable ____ confused ____ extreme ups/downs ____ jealous ____ hopeless ____ helpless

Describe any other feelings you have had that was not listed above. _____

Please check any of the following risk-taking behaviors that the child has been engaged in:

____ street racing ____ gang involvement ____ skipping school ____ dropped out ____ dangerous dieting ____ cutting ____ stealing ____ unprotected sex ____ running away
____ bullying others ____ fire starting ____ hurting small animals ____ restricting food intake ____ over exercise ____ drinking alcohol ____ using drugs

Please check any of the following alcohol/drugs that the child has used:

____ beer ____ wine ____ hard liquor ____ pot/marijuana ____ cocaine ____ heroin ____ Ecstasy ____ speed ____ over the counter drugs
____ prescription drugs ____ Triple C's ____ dons ____ quad bars other _____

Has your child ever considered or attempted suicide in connection with the current problem? _____

Has your child ever considered or attempted suicide in the past? _____

Has your child tried to hurt others or animals recently or in the past? _____

Has your child had any homicidal thoughts recently or in the past? _____

Please list your therapy goals:

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Printed Name: _____