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Child Assessment
(Ages 2-12)

Child's name_____ Today's Date_____
Child's birth date_____ Age_____ Sex_____ School attending_____
Grade_____ Religion_____ Race_____
Address_____ Length at address_____

Please provide information about who the child currently lives with:
Mother _____ Please circle one- Birth Adoptive Foster Step Other_____
Mother's Age_____ Mother's Phone #_____ Mother's Race_____
Mother's Marital Status_____ When married/divorced/separated?_____
Mother's Employer_____

Father_____ Please circle one- Birth Adoptive Foster Step Other_____
Father's Age_____ Father's Phone #_____ Father's Race_____
Father's Marital Status_____ When married/divorced/separated?_____
Father's Employer_____

If possible, please list names of parent(s) child does not currently live with: _____
_____
_____

Please list names, ages and relationship of other people living in the home:
_____
_____
_____

Describe the child's relationship with siblings_____
_____
_____

Describe the child's relationship with their biological father_____
_____
_____

Describe the child's relationship with their biological mother_____
_____
_____

Describe the child's relationship with any step/adoptive/foster/parent figure(s) _____
_____
_____

If parents are separated or divorced, what was the child's response? _____
_____
_____

What is the custody situation? Please circle one- joint sole with_____

What is the visitation situation? _____
_____
_____

If parents are separated or divorced, how is the current relationship with each other- civil, conflictual, etc.? _____
_____
_____

Presenting Problem- What's going on? Why are you seeking counseling at this time?
_____
_____
_____
_____
_____

Does your child have any of the following issues?

___	Night terrors	___	Bed wetting	___	Eating Disorder
___	Nail Biting	___	Stammering	___	Persistent Fears, Anxiety
___	Low self esteem	___	Overweight	___	Underweight
___	Frequent illness	___	Sleepwalking	___	Frequent Family Moves
___	Self Abuse	___	Sleep difficulties	___	Homicidal thoughts
___	Excessive guilt	___	Thumb sucking	___	Preoccupation with sex
___	Sexually active	___	Excessive shyness	___	Generally Unhappy
___	Trouble with friends	___	Depression	___	Delinquency from school

___ Other, please describe_____
_____

What do you hope to get out of counseling?
_____
_____
_____
_____

Emotional/Behavioral-

Rate the effect of your child's problems or emotional distress in each of the following areas:

	0 None	1-3 Mild	4-7 Moderate	8-10 Severe
Family	□	□	□	□
Other Relationships	□	□	□	□
Health/Physical well-being	□	□	□	□
School	□	□	□	□

Social and Developmental History-
Is your child able to make friends?_____
How would you describe your child's personality and temperament? _____
_____
Does your child have any developmental delays?_____
Is there a history of abuse, trauma, or loss? If yes, please describe_____
_____
_____
_____
Child's strengths, interests, accomplishments_____
_____
_____
_____
Daily Living Skills- does your child bath, eat, and dress themself appropriately? _____
_____

Education-
Does your child have an Individualized Education Plan (IEP)? Yes No
What is their relationship like with their teacher? _____
Do they participate in extracurricular activities? If so what? _____
How are their grades? _____
School Concerns? _____

Medical History/Problems-
List any allergies or significant medical problems your child has now or in the past _____
_____
If your child is on any medication- please list name, dose and reason they take it _____
_____

Doctor's Name_____ Phone #_____ Date of last visit_____

Has your child been in counseling before? If so, who with and what was the outcome?
_____
_____

Family Mental Health History-
Please list any family members (parents, siblings, aunts, uncles, grandparents) that have mental health issues such as depression, anxiety, ADD/ADHD, Schizophrenia, bi-polar, etc.
_____
_____

Alcohol/drug history-
Has your child used drugs or alcohol? Were they exposed to drugs or alcohol before birth?
_____
_____

Legal Issues-
Is your child involved in legal issues due to custody battle, crime victim, court case regarding abuse, DHS involvement/state custody, foster care, or other legal issue? _____
_____
_____

Parental Issues-

Have any parents recently quit a job, got a new job, or experiencing stress at work?

_____

Is there marital distress between parents child lives with? _____

_____

Are any parents involved in a legal battle, in jail, on probation, etc.?_____

_____

_____

Do any parents currently use drugs/alcohol? _____

_____

Family Issues-

Are siblings going through changes or stress? _____

Is extended family experiencing changes or stress- grandparents, aunts, uncles, cousins, etc?

_____

Any thing else you would like your child's counselor to know? _____

This section to be completed by the counselor

Appearance	□appropriate	□unclean	□disheveled	□dress	□unusual	
Behavior	□cooperative	□withdrawn	□guarded	□irritable	□threatening	□violent
Speech	□unremarkable	□pressured	□slow	□rapid	□loud	□soft
Mood	□euthymic	□depressed	□angry	□anxious/fearful	□labile	
Affect	□congruent	□incongruent	□flat,blunted	□restricted	□broad	
Sleep	□normal	□diminished	□excessive			
Appetite	□normal	□diminished	□excessive			
Energy	□normal	□diminished	□excessive			
Thinking	□goal directed	□linear	□loose assoc.	□tangential	□disorganized	
Orientation	□X3	□person	□place	□time		
Memory	□remote normal	□remote impaired	□recent normal	□recent impaired		
Intelligence	□average	□below average	□above average	□unclear		
Judgment	□normal	□impaired				
Insight	□normal	□diminished	□denial of illness	□unmotivated for treatment		
Hallucinations/Delusions		□none	□auditory	□visual	□other	

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: CGAS

Clinician's Signature_____ Date_____

Printed Name Colleen Adarhormazd Degree MA, QMHP, LPC