# Child Assessment (ages 2-12)

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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: _____
_____
_____
Siblings' names & ages: _____
Please list names, ages and relationship of other people living in the home: _____
_____
_____
Describe the child's relationship with any 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?
_____
_____
_____
_____
_____

What do you hope to get out of counseling? What are your counseling goals?_____
_____
_____
_____

Does your child have any of the following issues?

| | | | | | |
|---|---|---|---|---|---|
| ___ | Night terrors | ___ | Bed wetting | ___ | Toileting issues |
| ___ | Nail Biting | ___ | Stammering | ___ | Persistent Fears, Anxiety |
| ___ | Low self-esteem | ___ | Eating issues | ___ | Frequent illness |
| ___ | Sleepwalking | ___ | Anger/Aggression | ___ | Frequent Family Moves |
| ___ | Self-Harm | ___ | Sleep difficulties | ___ | Suicidal thoughts/actions |
| ___ | Excessive guilt | ___ | Thumb sucking | ___ | Sexual thoughts/actions |
| ___ | Excessive shyness | ___ | School issues | ___ | Sensitive to sensory issues/ |
| ___ | Trouble with friends | ___ | Depression | | sounds, touch, oral, visual |
| ___ | Other, please describe_____ | | | | |

**Emotional/Behavioral**-
Rate the effect of your child's problems/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 self appropriately? _____

**Education-**
Does your child have an Individualized Education Plan (IEP)? Yes No
What is their relationship with their teacher? _____
Do they participate in extracurricular activities? _____
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, with who and what was the outcome?
_____
_____

**Family Mental Health History-**
Please list any family members (parents, siblings, aunts, uncles, grandparents) that have mental health issues like 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- custody battle, crime victim, court case regarding abuse, DHS involvement/state custody, foster care, or other legal issue?
_____
_____

**Parental Issues-**
Is any parent under stress- recent job change/stress, move, health issues, etc?_____
_____
Is there marital distress between parents? _____
_____
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? _____
Extended family experiencing changes/stress- grandparents, aunts, uncles, cousins, etc?_____
**Spirituality-** Is your child involved in church/youth group/faith community?_____
Anything else you'd like the counselor to know?_____
_____