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CHILD INITIAL CLINICAL ASSESSMENT FORM

Date: _____ Child's Full Name: _____ Sex: _____

Child's Nickname/Preferred Name, if applicable: _____

Age: _____ Date of Birth: _____ Grade: _____ School: _____

Home Address: _____

Home/ Cell Phone: _____ Okay to leave message? Yes No

Parent/Guardian #1 Name: _____ **Email:** _____

Cell Phone: _____ Okay to leave message? Yes No

Does child live with this parent: Yes No

Parent/Guardian's Occupation/Employer: _____

Parent/Guardian #2 Name: _____ **Email:** _____

Cell Phone: _____ Okay to leave message? Yes No

Does child live with this parent: Yes No

Parent/Guardian's Occupation/Employer: _____

Marital status of Parents: ___ Single ___ Married ___ Divorced ___ Widowed
___ Domestic Partnership

Emergency Contact Information: Name: _____ Relationship: _____

Primary phone number: _____

Pediatrician: _____ Pediatrician's phone number: _____

Presenting Problem: Briefly describe the problems/concerns:

Household members, age and relationship:

What else do you feel/believe would be helpful, or important for us to know/understand about your relationships with your family or about your family members?

Developmental Milestones:

(Please note whether it was achieved early, late or within normal limits)

Rolled over

- Early Normal Late

Crawled

- Early Normal Late

Stood up

- Early Normal Late

Walked

- Early Normal Late

Sat without support

- Early Normal Late

Grasped pencil/crayon

- Early Normal Late

Fed self

- Early Normal Late

Spoke first words

- Early Normal Late

Sleep: What time does your child go to sleep? _____ What time does your child wake up? _____

Please briefly describe your child's nightly sleep routine:

Does your child sleep in his/her own room? Yes No

If yes, at what age did your child begin to sleep alone? _____

(Please check the following items that relate to your child's sleep):

- Difficulty staying asleep Difficulty falling asleep Frequent waking Sleep walking
 Night sweats Nightmares Enuresis (urinating on oneself) Encopresis (the soiling of the underwear) Recurrent nightmares

Victimization (please circle):

Physical abuse Sexual abuse Psychological Abuse Robbery victim
Assault victim Dating violence Domestic Violence
Human trafficking DUI/DWI crash Survivors of homicide victims

Other: _____

RECENT LOSSES: Family Member ____ Friend ____ Health ____ Job ____ Housing ____ None ____
Who? _____ When? _____

Nature of Loss? _____

Child's Behavior/Personality Traits:

- | | | |
|---|--|--|
| <input type="checkbox"/> Shy | <input type="checkbox"/> Immature | <input type="checkbox"/> Well-behaved |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Temper-tantrums |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Cries excessively | <input type="checkbox"/> Tells lies |
| <input type="checkbox"/> Thumb-sucking | <input type="checkbox"/> Head-banging | <input type="checkbox"/> Tics and Twitching |
| <input type="checkbox"/> Always in motion | <input type="checkbox"/> Excessively fidgety | <input type="checkbox"/> Difficulty paying attention |
| <input type="checkbox"/> Difficulty with transitions | <input type="checkbox"/> Difficulty finishing a task | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Angry | <input type="checkbox"/> Gets easily frustrated |
| <input type="checkbox"/> Has poor self-esteem | <input type="checkbox"/> Fears making mistakes | <input type="checkbox"/> Harm to animals |
| <input type="checkbox"/> Willing to try new activities | <input type="checkbox"/> Attentive | <input type="checkbox"/> Destructive/aggressive |
| <input type="checkbox"/> Fears of looking "stupid" | <input type="checkbox"/> Moods change quickly | <input type="checkbox"/> Cooperative |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Sees things that are not there | <input type="checkbox"/> Hears voices that are not there |
| <input type="checkbox"/> Engages in risky behavior | <input type="checkbox"/> Lacks judgment | <input type="checkbox"/> Uses drugs |
| <input type="checkbox"/> Drinks alcohol | <input type="checkbox"/> Skips school/classes | <input type="checkbox"/> Refuses to go to school |
| <input type="checkbox"/> Difficulty sharing | <input type="checkbox"/> Difficulty listening | <input type="checkbox"/> Difficulty understanding jokes |
| <input type="checkbox"/> Self-abusive behavior | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Argumentative |
| <input type="checkbox"/> Poor awareness of time | <input type="checkbox"/> Gets lost easily | <input type="checkbox"/> Becomes frightened easily |
| <input type="checkbox"/> Frequent Accidents | <input type="checkbox"/> Steals things | <input type="checkbox"/> Blames others |
| <input type="checkbox"/> Failure to take responsibility for actions | <input type="checkbox"/> Seems unable to empathize with others | |
| <input type="checkbox"/> Difficulty separating from caregiver | <input type="checkbox"/> Gets distracted while watching television | |
| <input type="checkbox"/> Moods seem to be connected with the seasons | <input type="checkbox"/> Difficulty making or keeping eye contact | |
| <input type="checkbox"/> Plays alone for a reasonable length of time | <input type="checkbox"/> Avoids being the center of attention | |
| <input type="checkbox"/> Difficulty staying at one task for a long period of time | | |
| <input type="checkbox"/> Rigid/Inflexible/unwilling to try new activities or new ways of doing things | | |

Compulsions (please list): _____

Obsessions (please list): _____

Fears (please list): _____

Currently Suicidal Yes No Has child been suicidal in the past? Yes No (If yes, please explain nature of ideation or attempt):

Homicidal (If yes, please explain nature of ideation or attempt):

Has your child ever inflicted burns or wound on his/herself? ____ Yes ____ No If so, please explain:

Do you have concerns about your child in the following areas? (check all that apply):

- Eating
- Hygiene/grooming
- Sleeping
- Activities/play
- Social Relationships

If so, please describe:

PREGNANCY & BIRTH HISTORY:

Were there any complications during pregnancy? • Yes • No If yes, please explain:

• Full-term Birth • Premature Birth Were there any complications during birth? • Yes • No If yes, please explain: _____

Were drugs or alcohol consumed during pregnancy? • Yes • No Child's weight at birth? _____

Was your child adopted? • Yes • No If yes, at what age? _____

Do they know they were adopted? _____ If so, at what age were they told? _____

How did they react to the news? _____

Current Medications:

Name: _____ Dose: _____

Reason Prescribed: _____

Name: _____ Dose: _____

Reason Prescribed: _____

Name: _____ Dose: _____

Reason Prescribed: _____

Medical Hospitalizations client has had in the past? (Surgeries, illness, accidents, etc.):

Reason

Date

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Is your child currently being seen by a counselor? • Yes • No

If yes, name of current counselor _____ Length of Treatment _____

Is your child currently being seen by a psychiatrist? • Yes • No

If yes, name of current psychiatrist _____ Length of Treatment _____

Has your child ever been diagnosed with a mental health, emotional or psychological condition?

• Yes • No

If yes, what diagnosis was your child given? _____

When? _____

By Whom? _____

Has your child received counseling services or been hospitalized for mental health or drug and alcohol concerns in the past? • Yes • No

If yes, please list previous counseling/hospitalizations for mental health/drug and alcohol concerns:

Education:

Please check any of the following problems reported by your child’s school or teacher:

- Reading
- Writing
- Math
- Behavior
- Social Adjustment
- Attention Span
- Spelling
- Distractibility
- Hyperactivity
- Following Directions
- Getting along with other children
- Getting along with teachers
- Does not complete homework readily

Please describe your child’s attitude towards school:

Has your child ever missed an extended amount of school?

If so, please explain:

Please check if your child has any of the following?

- Special Education Accommodations or a 504? Please describe: _____
- An Individualized Education Plan (IEP)? Please describe: _____
- Diagnosed Learning Disability? Please describe: _____
- Receiving special services at school? Please describe: _____

HOUSING: Would you consider your housing to be: • stable • unstable If unstable, please describe:

Please choose the one that best describes the current housing arrangement for this child:

- Parent/Guardian owns home
- Parent/Guardian rents home
- Child and family live with relatives/friends (temporary)
- Child and family live with relatives/friends (permanent)
- Homeless
- Emergency Shelter

How long has this child lived in the current living situation?

How many times has the child moved in the past two years?

FOSTER CARE INVOLVEMENT: Has your child ever been in foster care? • Yes • No • Unknown

From _____ age to _____ age **Reason:** _____

Type of Placement: • Familial Placement • Non-Familial Placement

Family Mental Health History:

In the section below identify if there is a family history or if you have any issues with any of the following. If yes, please indicate the family member's relationship to you (father, maternal grandmother, paternal uncle, etc.).

Alcohol/Substance Abuse: yes/no _____

Anxiety: yes/no _____

Depression: yes/no _____

Bipolar Disorder: yes / no _____

Domestic Violence: yes/no _____

Eating Disorders: yes/no _____

Obesity: yes/no _____

Obsessive Compulsive Behavior: yes/no _____

Schizophrenia: yes/no _____

Suicide Attempts: yes/no _____

Homicide or Attempts: yes / no _____

Sexual Abuse of client or other family members: yes / no _____

Social and Emotional Development: Describe your child's current social skills and peer relationships:

Please note if your child has a history of being bullied/teased or has been aggressive in play with others:

How would you describe your child socially? How do you think your child interacts with peers while at school?

Does your child have difficulty keeping friends? _____
Does your child have a best friend? If so, how often do they interact at home or away from school?

Please list your child's favorite hobbies, activities, and games, other than sports (e.g. piano, books, dolls, crafts, cars, etc.). Please describe how well you feel your child does in these areas:

Which sports does your child most enjoy playing? Describe how well your child does in these sports compared to peers: _____

Please list any additional organizations, clubs, teams, or groups in which your child participates:

How does your child handle stress?

What are your child's strengths?

In what areas would you like to see your child stronger?

Form completed by: _____ Relationship to child: _____
Therapist: _____ Date: _____

ALCOHOL/DRUG ASSESSMENT:

Does your child use tobacco or smokeless tobacco? • Yes • No • Do not know

Does your child use alcohol or drugs? • Yes • No • Do not know

To your knowledge, has your child ever used medications (prescriptions drugs or over the counter medication) recreationally? • Yes • No • Do not know

To your knowledge, has your child ever overdosed or passed out on alcohol or other drugs?

• Yes • No If yes, when was the last overdose? _____

Has your child ever experienced problems related to their alcohol use? • Yes • No

If yes, please check area and describe problems:

• Legal • Social/Peer • Work • Family • Friends • Financial

Please describe: _____

If yes, have they continued to drink/use drugs? • Yes • No

LEGAL INVOLVEMENT:

Is there a current custody case involving your child? • Yes • No If yes, please describe below.

History of CPS / DSS involvement: • None • Past • Current Please describe below.

Please indicate by checking your child's legal status below.

• No Involvement • No Involvement • Probation / Length: _____ • Parole | Length: _____
• Charges Pending • Prior Incarceration • Law Suit or other Court Proceeding

Charges: _____ Probation/Parole Officer's Name: _____

Contact #: _____

CURRENT NEEDS/GOALS: What do you feel is your child's biggest need right now?

What do you most hope to gain from coming to counseling?

Strengths, Needs, Abilities and Preferences:

Strengths: (Family, social, spiritual & hobbies that have helped overcome past crises):

Needs: (Client's expression of current needs: emotional, physical & environmental):

Abilities: Client's ability to follow up with treatment _____(yes/no), Client understands instructions & is willing to participate in treatment _____(yes/no).

Preferences: Appointment day/evening (circle).

Are you currently seeking treatment from another provider: Yes/No

Who does/can your child count on for support? ▪ Parents ▪ Boyfriend/Girlfriend ▪ Siblings
 ▪ Extended Family ▪ Friends ▪ Neighbors ▪ School Staff ▪ Church ▪ Pastor ▪ ▪ Therapist
 ▪ Group ▪ Community Services ▪ Doctor ▪ Other: _____

MENTAL STATUS				
<i>Affect</i>	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Blunted	<input type="checkbox"/> Constricted	<input type="checkbox"/> Flat <input type="checkbox"/> Labile
<i>Appearance</i>	<input type="checkbox"/> Well-groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Inappropriate	
<i>Attitude</i>	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input type="checkbox"/> Uncooperative	
<i>Mood</i>	<input type="checkbox"/> Euthymic	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	<input type="checkbox"/> Euphoric
<i>Motor Activity</i>	<input type="checkbox"/> Calm	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Agitated	<input type="checkbox"/> Tremors/Tics
<i>Thought Process</i>	<input type="checkbox"/> Intact	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Tangential	<input type="checkbox"/> Loose assoc.
<i>Thought Content</i>	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions	
<i>Orientation</i>	<input type="checkbox"/> Fully oriented	Disoriented as to: <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person		

Diagnosis:

Criteria for Diagnosis:
