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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

Sat without support
□ Early □ Normal □ Late

Crawled
□ Early □ Normal □ Late

Grasped pencil/crayon
□ Early □ Normal □ Late

Stood up
□ Early □ Normal □ Late

Fed self
□ Early □ Normal □ Late

Walked
□ 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 wakening □ 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:

□ Shy	□ Immature	□ Well-behaved
□ Stubborn	□ Impulsive	□ Temper-tantrums

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□ Self-abusive behavior □ Withdrawn □ Argumentative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

Compulsions (please list): ____
Obsessions (please list): ____
Fears (please list): ____
Issues with Shoplifting: ____

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: ___________________________________

OFFICE USE ONLY:

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

Diagnosis:

____

____

____

Criteria for Diagnosis:

________ ____

________ ____

________ ____