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CHILD INITIAL CLINICAL ASSESSMENT FORM

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

Gender:_____ Age: _____

Date of Birth: _____Grade:_____School:_____

Home Address: _____

Cell Phone:_____Okay to leave message? ___ Yes ___ No

Insurance Number: _____

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 ____ Dom Partner

Pediatrician: _____Pediatrician's phone number: _____

Presenting Problem: Briefly describe the problems/concerns:

_____
_____
_____

Household members, age and relationship:

_____
_____
_____
_____

Developmental Milestones: ___ All On Time ___ Cl was late developmentally with:_____

Sleep: Briefly describe your child's nightly sleep routine:

_____

_____

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

Victimization (*please circle)*:

Physical abuse	Sexual abuse	Emotional Abuse	Robbery victim
Assault victim	Dating violence	Domestic Violence	Human trafficking

Other: _____

_____

RECENT LOSSES: Family Member ____ Friend _____ Health ____ Job ____ Housing _____
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 drugs or alcohol consumed during pregnancy?__ Yes __ No Child's birth weight: _____
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: _____Reason Prescribed: _____Dose:_____

Name: _____Reason Prescribed: _____Dose:_____

Name: _____Reason Prescribed: _____Dose:_____

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: _____
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 __ 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

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: 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?

_____

_____

Please list your child's favorite hobbies, activities, and games, other than sports (e.g. piano, books, dolls, crafts, cars, etc.): _____

_____

_____

How does your child handle stress?

_____

_____

What are your child's strengths? _____

_____

ALCOHOL/DRUG ASSESSMENT:

Does your child use tobacco or smokeless tobacco? ___ Yes ___ No

Does your child use alcohol or drugs? ___ Yes ___ No

To your knowledge, has your child ever used medications (prescriptions drugs or over the counter medication) recreationally? ___ Yes ___ No

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 ___ Probation Length: _____Parole Length: _____

___ Charges Pending ___Prior Incarceration ___ Lawsuit 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?

_____

OFFICE USE ONLY:

Therapy recommended: Check all that apply: ____ Individual ____ Family

Frequency Check: ___ Weekly ___ Twice a Week ___ Other _____

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:

_____

_____

Justification for Diagnosis: _____ ICA _____ PCP/Psychiatrist _____Cross Cutter

Form completed by: _____Relationship to child: _____

By signing these documents, therapist has deemed that the recommended services are medically necessary to restore functioning related to:

□ Home □ School □ Work □ Cognitive Functioning □ Social/Interpersonal Functioning,

Caused by mental health diagnosis.

Therapist: _____

Therapist Signature: _____Intake Date: _____