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CHILD INITIAL CLINICAL ASSESSMENT FORM

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

Gender: _____ Age: _____ Gender Identity: _____

Date of Birth: _____ Grade: _____ School: _____

Home Address: _____

Cell Phone: _____ Okay to leave message? ___ Yes ___ No

Insurance Company & Number: _____

Parent/Guardian #1

Name: _____ Email: _____

Cell Phone: _____ Okay to text/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 text/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 ___ CI was developmentally delayed

Explain: _____

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 waking
- 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 |

Explain: _____

RECENT LOSSES: Family Member ___ Friend ___ Health ___ Job ___ Housing ___

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 |

Client Name: _____ Insurance #: _____

- 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):

Homicidal (If yes, please explain):

Has your child ever inflicted burns or wounds 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 or birth? ___ 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? _____

Client Name: _____ Insurance #: _____

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:

Has your child been seen by a counselor before? ___ Yes ___ No

If yes, how long ago and counselors name: _____

Length of Treatment _____ Counselors contact info: _____

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

If yes, name of current psychiatrist contact info: _____

Length of Treatment _____

Has your child ever been diagnosed with a mental health 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Writing | <input type="checkbox"/> Math |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Social Adjustment | <input type="checkbox"/> Attention Span |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Following Directions | <input type="checkbox"/> Getting along with other children | |
| <input type="checkbox"/> Getting along with teachers | <input type="checkbox"/> 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: _____

Client Name: _____ Insurance #: _____

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 _____

Explain if yes: _____

Homicide or Attempts: yes / no _____

Explain if yes: _____

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

Explain if yes: _____

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? _____

Explain if yes: _____

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

Explain if yes: _____

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 If yes: Probation Length: _____ Parole Length: _____

Charges Pending Prior Incarceration Lawsuit or other Court Proceeding

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

Contact #: _____

Client Name: _____ Insurance #: _____

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				
<i>Affect</i>	• Appropriate	• Blunted	• Constricted	• Flat • Labile
<i>Appearance</i>	• Well-groomed	• Disheveled	• Inappropriate	
<i>Attitude</i>	• Cooperative	• Guarded	• Uncooperative	
<i>Mood</i>	• Euthymic	• Depressed	• Anxious	• Euphoric
<i>Motor Activity</i>	• Calm	• Hyperactive	• Agitated	• Tremors/Tics
<i>Thought Process</i>	• Intact	• Circumstantial	• Tangential	• Loose assoc.
<i>Thought Content</i>	• Appropriate	• Hallucinations	• Delusions	
<i>Orientation</i>	• 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:** _____

(If Applicable) Supervisor signature required for LPCA /Intern providers only.

Supervisor Name Printed: _____

Supervisor Signature: _____

Client Name: _____ Insurance #: _____