

Child Assessment Form

Child's Name: _____ Date: _____

Birth date: _____ Gender: M F Age: _____

Telephone number: _____ Is it ok to leave a message? _____

Cell phone numbers: _____

Address: _____

City: _____ State: _____ Zip code: _____

Information supplied by (name and relationship to the client): _____

Presenting problem(s) or why you are seeking therapy (briefly):

What symptoms or changes have you seen in your child?

When did you first notice these changes in the child (approximately)? _____

Child's Demographics

Child's full legal name: _____

Ethnic identification: _____ Year in school _____

Name of School _____ Teacher's Name _____

Child's current residence: (please check one) _____ With biological parents

_____ With Foster Parents _____ With Adoptive Parents _____ Other

If "other," please explain: _____

Residential Parents' Demographics

Parent 1: _____ Birth date: _____

Employer: _____

Occupation: _____

Ethnic Identification: _____

Parent 2: _____ Birth date: _____

Employer: _____

Occupation: _____

Ethnic Identification: _____

List Other Parents who are not living with child: _____

Custody and Legal School District of Residence

Who has legal custody of the child? _____
_____ Temporary _____ Permanent

Parents' Marital History/Current History

Mother: _____ Father: _____
Married To: _____ Married To: _____
Separated From: _____ Separated From: _____
Divorced From: _____ Divorced From: _____
Remarried To: _____ Remarried To: _____

Family and Home Information

All persons currently living in the household:

Name	Birth date	Sex	Education level	Relationship
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

Has the child lived with both parents since birth? _____ No _____ Yes

If "no," list changes chronologically (include residential placements). Please list dates or child's age in the spaces below:

From:	To:	Child lived with:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If child is not living with both birth parents, please list reason:

_____ Parents separated _____ Parents divorced _____ Parent deceased _____ Other

If "other," please explain: _____

If the child has a parent not living with the child, are there visitations?

_____ Yes How frequently: _____
_____ No Reason: _____

If there are any other children living in the family:

A. Do any of them have physical or emotional problems? _____ No _____ Yes

If "yes," please explain: _____

B. If "yes," have they received counseling or other forms of help? No Yes
If "yes," please explain: _____

Is your house troubled by domestic violence (now or in the past)? No Yes
If "yes," please explain: _____

Does any family member have an alcohol or drug problem (now or in the past)?
 No Yes

If "yes," please explain: _____

Child's Developmental and Medical History

Was the pregnancy of this child planned? No Yes

Were there any prenatal problems during pregnancy? No Yes

If "yes," please explain: _____

List any drugs used by mother or father at the time of conception, or by the mother during pregnancy: _____

Were there any problems during delivery? No Yes

If "yes," please explain: _____

Birth weight: _____ lbs _____ oz.

Infancy:

A. Did the child's mother suffer from post-partum depression following this child or any other child's birth? No Yes

If "yes" please explain: _____

B. Were there any stressful events that occurred in the family after this child's birth?
 No Yes

If "yes" please explain: _____

C. Were there any feeding problems? No Yes

If "yes," please explain: _____

D. Did your child sleep well? No Yes

If "no," please explain: _____

E. At what age was your child toilet trained? _____
Were there any difficulties? _____

Were any of the following present during the first few years?

- | | |
|------------------------------|------------------------------------|
| _____ Did not enjoy cuddling | _____ Was not calmed by being held |
| _____ Difficult to comfort | _____ Colic |
| _____ Excessive restlessness | _____ Excessive irritability |
| _____ Frequent head banging | _____ Constantly into everything |
| _____ Reflux | _____ Listless/Unresponsive |

How would you describe the following for your child in infancy and toddlerhood?

- Activity level: _____ Under active _____ Average activity level _____ Overactive
Adaptability: _____ Adapted easily to change _____ Resisted change
Intensity: _____ Average _____ Feelings were often intense
Mood: _____ Often happy _____ Average range of moods _____ Often irritable

At what age did your child:

- _____ Wean _____ Walk _____ Sit up alone _____ Talk

Were there any difficulties? _____

Are there any problems with bedwetting/accidents? _____ No _____ Yes

- _____ Night _____ Frequency
_____ Daytime accidents _____ Frequency

Does or did your child ever have multiple ear infections? _____ No _____ Yes

Does or did your child have allergies? _____ No _____ Yes

If "yes," to what does the child have allergies? _____

Please detail any of your child's hospitalizations:

Date	Age	Hospital	Reason	Length of stay
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has your child ever experienced head injuries or serious illness? _____ No _____ Yes If

"yes" please explain: _____

Name of primary physician and phone number: _____

What medications is your child currently taking? _____

your child currently experiencing any medical problems? No Yes

If "yes" please explain: _____

Are there any physical concerns (e.g. head trauma, seizures, etc.) No Yes

If "yes", please explain: _____

Agency Involvement/Service Treatment History

Please include (chronologically if possible) as complete a history as possible. Include agencies, physicians, counselors, institutions, therapists, etc.

Date	Age	Contact person	Services provided	Length of involvement
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has your child been court involved? No Yes

If "yes," please explain: _____

Child's School History

School attendance:

	Date	Location	Problems (Y/N)	Teacher
Preschool	_____	_____	_____	_____
Kindergarten	_____	_____	_____	_____
Grade 1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____
7	_____	_____	_____	_____
8	_____	_____	_____	_____
9	_____	_____	_____	_____
10	_____	_____	_____	_____
11	_____	_____	_____	_____
12	_____	_____	_____	_____

If answered "yes," to problems at any academic level, please detail here. Please give any information about treatment (if any) provided by the school at the time of occurrence:

Is your child in any resource or special classes? _____ If "yes" please describe:

Has your child had any conduct or behavior problems in school? _____

If "yes" please describe: _____

How would you rate your child's homework/study skills? (circle one) Good Average Poor

Describe any difficulties: _____

Has your child had tutoring or remedial work? _____ If "yes" please describe:

Does your child like to read? _____ How often: _____

With whom does the child read: (circle one) Mother Father Siblings Alone

Please rate reading ability: (circle one) Good Fair Poor

Typical Day Descriptions

A. On a school day, how does the child awaken? (by himself, by you, etc.)

B. How does your child prepare himself for the day? (Who selects clothing, etc.?)

C. Does the child ready himself quickly or require continual reminding?

D. Does the child eat breakfast? _____ No _____ Yes If so, who prepares it?

E. Does the child watch the time and leave promptly or is frequent reminding necessary?

F. Does the child come home for lunch? _____ No _____ Yes

If so, who prepares it? _____ Any problems? _____

Does the child watch the time and leave promptly or is frequent reminding necessary? _No

_____ Yes

G. What does the child do after school? _____

H. What occurs at dinnertime? _____

1. Does the family eat together? _____No _____Yes
2. Is the child on time? _____No _____Yes
3. Are there any problems during dinner? _____No _____Yes
4. Does he/she participate in family conversations during meals? _____No _____Yes

If you answered "no," to any or these questions, or "yes," to question 3, please explain: _____

I. What occurs after dinner?

J. What happens at bedtime?

K. What does the child do on weekends?

Friday evening: _____

Saturday: _____

Sunday: _____

L. Does your family have much "family time" together (shopping, movies, games, etc.)?

M. What activity do you enjoy most with your child? _____

N. Does your child spend time with friends? _____

How much time on a weekly basis? _____

How many friends does you child have? _____

How do you feel about your child's friends? _____

O. Does your child belong to any clubs, groups, or organizations?

If so, which ones: _____

P. Does you child have any interests or hobbies?

Q. Does you child get an allowance? _____No _____Yes

If so, is it earned or given? _____

How does the child manage the money? _____

R. Does your child have specific chores? _____No _____Yes

If so, what are they? _____

Does you child try to avoid doing chores? _____No _____Yes

What does he do to try to avoid them (refuse, argue, etc.)? _____

S. What methods do you use to discipline your child? _____

How often is it necessary? _____

Does it work? _____

Behavior Checklist

Check the behaviors listed below that apply to your child within the past 6 months.

- Makes no sounds.
- Makes sounds but says no words.
- Says a few words (Please specify): _____
- Speaks well but was slow in developing speech.
- Repeats words over and over.
- Was speaking but is no longer.
- Is clumsy and awkward.
- Is often drowsy.
- Displays stereotypic behaviors (for example: wave hands in front of face, stares blankly, etc.)
If so, which ones: _____
- Engages in self-destructive behaviors:
 hair pulling self-biting self-pinching head banging
 other (Please specify): _____
- Has tantrums frequently.
- Is hyperactive.
- Seldom makes eye contact.
- Demands too much attention.
- Is often sluggish or slow moving.
- Often has physical complaints (i.e., headaches, stomachaches, etc.).
- Usually plays alone.
- Disobedience, difficulty with disciplinary control.
- Asks for help when it is not needed.
- Gives up easily.
- Does not interact appropriately with:
 Parents Siblings Peers Others
- Physically abuses:
 Parents Siblings Peers Pets Toys Furniture
- Cries, whines, or pouts frequently.
- Unreasonable noise, yelling.
- Does not play with toys.
- Rarely obeys requests, commands, etc.
- Talks back to parents or other authority figures.
- Reacts poorly when losing a game.
- Unreasonable fears (heights, animals, the dark, etc.) Please specify: _____

- Does not recognize danger.
- Runs away frequently.

- Does not observe curfew.
- Will not play alone.
- Problems at mealtimes (disruptive, selective about foods).
- Has a sleeping problem.
- Cannot feed self.
- Cannot dress self.
- Is not toilet trained.
- Is toilet trained but: wet pants, soils pants, wets bed.
- Frequent lying.
- Sets fires.
- Steals.
- Seems to have a hearing problem.
- Seems to have a vision problem.
- Other physical handicap (Please specify): _____
- Negative comments to:
 - Parents Siblings Peers Others
- Teasing of:
 - Parents Siblings Peers Others
- Complaining.
- Wanders off.
- Sadness.
- Complaints from neighbors.
- Police contact.
- School contact.

Please describe other problems: _____

What behavior distresses you the most? _____

What do you think are your child's greatest strengths? _____

Please describe the changes you hope to see in your child as a result of our work:

Referral1 Information

If you were referred by another professional (physician, clergy, therapist, etc.) please fill out the information below:

Name of referring professional

Address

City, State, ZIP Code

May we have your permission to notify the referring professional that you have participated in your first session of therapy and thank them for their referral?

_____ Yes _____ No

If you wish us to continue receiving information from and/or providing information to the referring professional regarding your treatment, please complete an “Authorization to Release Information Form.”