Minds Matter Behavioral Health

Children/Adolescent Psychosocial Assessment

To assist us in completing our assessment and in planning appropriate services, we need the following information. If some of the questions do not apply to you, please mark N/A. If you are the guardian, please complete the form on the person who is seeking services.

Identifying Information

Child's Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: _____

Address: _____
Street

_____ _____ _____
City State Zip

Phone #: _____ Person filling out form: _____

Name of person responsible for bill: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Parents/Stepparents

Mother's name: _____ Age: _____ Education: _____ Occupation: _____

Father's name: _____ Age: _____ Education: _____ Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____ Occupation: _____

Marital status of parents: _____ If separated/divorced, how old was the child at the time of the separation? _____

With whom does the child live? _____

Custody: ☐ lives in one home with both legal parents ☐ mother has physical custody ☐ father has physical custody

☐ physical custody is shared ☐ other: _____

List all people living in household:

Name	Age	Relationship to child

If any brothers or sisters are living outside the home, list their names and ages:

_____ _____

_____ _____

_____ _____

Family Information:

Place of birth: _____

Child's Race:

☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian

☐ African American ☐ Other (describe) _____

Was the child adopted? ☐ Yes ☐ No If yes, at what age? _____ From where? _____

Has the child ever been placed outside of the home? ☐ Yes ☐ No If yes, where? _____

In how many residencies has the child lived since birth? _____

Has the child been physically or sexually abused, assaulted, or molested? ☐ Yes ☐ No ☐ Unknown

If yes, specify by whom and when: _____

Have the child's parents or any other family members had any mental health or emotional problems?

☐ Yes ☐ No If yes, describe: _____

Primary Language: _____ Interpreter Needed: ☐ Yes ☐ No

Referral Source and Reason

Were you referred by? ☐ Physician ☐ Family ☐ Friend ☐ School ☐ Employer ☐ Other (If other, who?) _____

Reason for seeking services: _____

_____

_____

_____

Minds Matter Behavioral Health

History of Presenting Problem and Services Desired

When did you first think there might be a problem? _____

_____

_____

What seems to help the problem? _____

What seems to make the problem worse? _____

Is the problem worse at certain times, situations, or places? If yes, please explain. _____

_____

_____

Is the child on medication at this time? ☐ Yes ☐ No

How do you want your child's situation to be different after coming here? _____

_____

Social and Behavior Checklist

Place a check next to any behavior or problem that your child currently exhibits.

___ Has difficulty with speech
___ Has difficulty with hearing
___ Has difficulty with language
___ Has difficulty with vision
___ Has difficulty with coordination
___ Prefers to be alone
___ Does not get along well with other children
___ Is aggressive
___ Is shy or timid
___ Has poor bowel control (soils self)
___ Is more interested in things (objects) than in people
___ Engages in behavior that could be dangerous to self
___ Wets bed
___ Shows daredevil or risky behavior
___ Is impulsive
___ Other (describe) _____

___ Has frequent tantrums
___ Has frequent nightmares
___ Has trouble sleeping (describe) _____
___ Has blank staring spells
___ Rocks back and forth
___ Bangs head
___ Holds breath
___ Eats poorly
___ Is stubborn
___ Is much too active
___ Is slow to learn
(describe) _____
Has special fears, habits, or mannerisms
___ Gives up easily
___ Suck thumb

Describe the child's relationship with:

Father: _____

Mother: _____

Sibling(s): _____

Stepparent(s): _____

Other Interpersonal Relationships:

Describe the child's friendships:

☐ No friends ☐ Only acquaintances ☐ Both acquaintances and close friends

How many close friends? _____

Educational History

School: _____ Grade: _____

Place a check next to any education problem that your child currently exhibits:

___ Has difficulty with reading

___ Has difficulty with arithmetic

___ Has difficulty with spelling

___ Has difficulty with writing

___ Has difficulty with other subjects (please list)

_____

_____

___ Does not like school

Does your child receive special education services? ☐ Yes ☐ No

Has your child been held back in a grade? ☐ Yes ☐ No

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever been suspended or expelled? ☐ Yes ☐ No

If yes, please describe: _____

Developmental History

During pregnancy, was the mother on medication? ☐ Yes ☐ No If yes, what kind? _____

During pregnancy, did the mother smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? _____

During pregnancy, did mother drink alcoholic beverages? ☐ Yes ☐ No If yes, specify type _____

Approximately how much alcohol was consumed each day? _____

During pregnancy, did the mother use drugs? ☐ Yes ☐ No If yes, what kind? _____

Were forceps used during delivery? ☐ Yes ☐ No

Was a cesarean section performed? ☐ Yes ☐ No If yes, for what reason? _____

Was the child premature? ☐ Yes ☐ No If so, by how many weeks? _____

What was the child's birth weight? _____

Were there any birth defects or complications? ☐ Yes ☐ No If yes, please describe: _____

_____

Were there any feeding problems? ☐ Yes ☐ No If yes, please describe: _____

_____

Were there any sleeping problems? ☐ Yes ☐ No If yes, please describe: _____

_____

As an infant, was the child quiet? ☐ Yes ☐ No

As an infant, did the child like to be held? ☐ Yes ☐ No

Were there any special problems in the growth and development of the child during the first few years? ☐ Yes ☐ No

If yes, please describe: _____

_____

Minds Matter Behavioral Health

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to parent	_____	Put several words together	_____
Rolled over	_____	Dressed self	_____
Sat alone	_____	Became toilet trained	_____
Crawled	_____	Stayed dry at night	_____
Walked alone	_____	Fed self	_____
Babbled	_____	Rode tricycle	_____
Spoke first word	_____		_____

Current Health Information:

Describe the child's health generally: ☐ Good ☐ Fair ☐ Poor Is the child sexually active? ☐ Yes ☐ No

List any health problems the child has had: _____

_____

Does the child have:

Current immunizations	☐ Yes	☐ No	If no, which are needed? _____
Any allergies	☐ Yes	☐ No	Specify: _____
Nutritional problems	☐ Yes	☐ No	Specify: _____
Appetite problems	☐ Yes	☐ No	Specify: _____
Sleep problems	☐ Yes	☐ No	Specify: _____
A disability/handicap	☐ Yes	☐ No	Specify: _____
Contagious or other diseases	☐ Yes	☐ No	Specify: _____
Any accidents or injuries	☐ Yes	☐ No	Specify: _____
Dental/Vision/Hearing Concerns	☐ Yes	☐ No	Specify: _____
Any hospitalizations?	☐ Yes	☐ No	Specify: _____

Minds Matter Behavioral Health

Physician: _____ _____
Name City

Date of last contact: _____ / _____ / _____ Reason for last contact: _____

Family Medical History:

Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child.

___ Alcoholism

___ Cancer

___ Learning disability

___ Heart trouble

___ Bipolar disorder

___ Other (specify): _____

___ Depression

___ Diabetes

___ ADHD

___ Intellectual disability

___ Anxiety disorder

Substance Use

Do the child use any of the following *(include use of street drugs and/or prescription drugs)*?

	Age of Onset	Length of Use	Frequency of Use	Present Use	
Alcohol	_____	_____	_____	☐ Yes	☐ No
Stimulants	_____	_____	_____	☐ Yes	☐ No
Cocaine	_____	_____	_____	☐ Yes	☐ No
Tranquillizers	_____	_____	_____	☐ Yes	☐ No
Barbiturates	_____	_____	_____	☐ Yes	☐ No
Mariuana	_____	_____	_____	☐ Yes	☐ No
Opiods	_____	_____	_____	☐ Yes	☐ No
Hallucinogens	_____	_____	_____	☐ Yes	☐ No
Prescribed	_____	_____	_____	☐ Yes	☐ No
Nicotine	_____	_____	_____	☐ Yes	☐ No
Caffeine	_____	_____	_____	☐ Yes	☐ No
Other	_____	_____	_____	☐ Yes	☐ No

Spiritual/Religious Practices/Beliefs:

Religious preference: _____

☐ active ☐ inactive ☐ experiencing spiritual/religious distress Explain: _____

_____

Legal History

Legal involvement: ☐ none ☐ past ☐ present Describe: _____

Relevance to current problem: ☐ No ☐ Yes Describe: _____

Other Information:

What are your child's favorite activities?

_____ _____

_____ _____

_____ _____

What activities does your child like the least?

_____ _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check mark next to each technique used.

___ Ignore problem behavior

___ Scold child

___ Spank child

___ Threaten child

___ Redirect child's interest

___ Tell child to sit on a chair

___ Send child to their room

___ Take away a desirable object or activity

___ Reason with child

___ Other (specify): _____

Which disciplinary techniques are usually effective? _____

_____

With what type of problem(s)? _____

_____

Which disciplinary techniques are usually ineffective? _____

_____

With what type of problem(s)? _____

_____

What have you found to be the most satisfactory ways of helping your child? _____

_____

What are your child's assets or strengths? _____

_____

Previous Counseling/Psychotherapy:

Past mental health treatment: ☐ Yes ☐ No

If yes, specify where and when: _____

Do your child have any mental health diagnoses? If so, please list them: _____

_____

Has your child ever been hospitalized for mental health reasons: ☐ Yes ☐ No

If yes, when: _____

Has your child been prescribed psychotropic medication? ☐ Yes ☐ No

Please list medications and prescribing doctor: _____

_____

Has your child been prescribed any non-psychotropic medication? ☐ Yes ☐ No

Please list medications and prescribing doctor: _____

_____

Has the child ever:

Made a suicide attempt: ☐ Yes ☐ No If yes, when? _____

Expressed homicidal thoughts? ☐ Yes ☐ No If yes, describe: _____

_____

Had episodes of explosive anger: ☐ Yes ☐ No Describe: _____

_____

Is the child currently expressing homicidal or suicidal thoughts? ☐ Yes ☐ No

If yes, has the child expressed a plan to carry out the thoughts? ☐ Yes ☐ No

Signature of Informant _____ Date _____

Relationship to Client _____

Signature of Therapist _____ Date _____