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[child-adolescent-therapist.com](http://child-adolescent-therapist.com)  
CA License: MFC 33517

<h2>Child and Adolescent Initial Assessment</h2>
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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Who has current custody/guardianship of child? Mother Father Both Parents

Relative \_\_\_\_\_ Other \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Spouse/Partner: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred By: \_\_\_\_\_

Where would you like us to leave reminder messages: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell Phone \_\_\_\_\_

In the event of an emergency with client/child, whom should we contact: Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

### Childs Symptoms and Behaviors

Presenting Problem(s): Please state your concerns; specify nature of problem, duration, frequency, and severity: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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What are the most important issues you would like your child or teen to work on in therapy? \_\_\_\_\_

Does your child have behavior problems in the community (e.g. on probation, truancy, legal problems)?

Does your child have any past/ current substance use/abuse? cigarettes drugs alcohol  
drugs/alcohol denies use remission 90+ days none. If yes, please describe substances used, amount, and effect on child's performance at home and school: \_\_\_\_\_

Please indicate how the following symptoms/problems/complaints are effecting your child/teen:  
 1)Little effect 2)Some effect 3)Much effect 4)Significant effect (Leave blank if no effect)

Isolates / Withdraws	Generalized Anxiety	Weight Change
Irritability	Fatigue / Decrease in Energy	Provokes Others
Panic Attacks	Frequent Angry Outbursts	Gang Involvement
Hyperactive	Increase or loss of Appetite	School Avoidance
Runs Away	Cruelty Towards Animals	Quick Tempered
Mood Swings	Aggression Towards Others	Sexual Behaviors
Separation Anxiety	Sees Things That Aren't There	Speech Difficulties
Tearfulness	Difficulty Concentrating	Little or No Friends
Racing Thoughts	Self-Harming Behaviors / Cutting	Poor Social Skills
Breaks the Law	Frequent Stomachaches / Headaches	Binging / Purging
Bullied by Others	Suicidal Thoughts / Attempts	Cries Easily
Learning Problems	Loss of Interest in Activities	Frequent Fighting
Steals	Wets / Soils Bed or Clothes	Nightmares
Worry / Fear	Fire-Setting / Play with Fire	Hopelessness
Sadness	Problems Falling or Staying Asleep	Repetitive Movements
Disobedient / Defiant	Inattentive / Distractible	Hearing Voices

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## Child's School History

Current School District: \_\_\_\_\_ Grade: \_\_\_\_\_

School Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Review history of school functioning including strengths: (Gifted or accelerated learning program, learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement):

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Teacher/Counselor/IEP Coordinator: \_\_\_\_\_

Is child enrolled in special education?  Yes  No Current IEP? (if yes, request copy)

Child is designated:  Emotionally Disturbed (ED)  Specific Learning Disability (SLD)  Other \_\_\_\_\_

Child's classroom is:  Regular Education  Regular Education with pull-out to Resource Room

Special Education classroom (all day)  Inclusion in regular education (\_\_\_\_\_ hours/day)

Other: \_\_\_\_\_

What school interventions have been used to address problems:  None  Special seating arrangement

Tutoring  Groups  Classroom aide  Parent(s) called

other: \_\_\_\_\_

Has the child been suspended/expelled in past 12 months?  Yes  No If yes, how many times and the reason? \_\_\_\_\_

## Child's Health

Starting with birth and proceeding up to the present, list all allergies, diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had: \_\_\_\_\_

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Has your child ever had any previous psychotherapy? If so, where, how long, and did you feel it was helpful? \_\_\_\_\_

Physician Name and Number: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Psychiatrist Name and Number: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

<b>Prescribed medications:</b>	<b>Purpose:</b>	<b>Dose:</b>	<b>Side Effects:</b>

### Family History

<b>Relatives That Live in the Home:</b>	<b>Name:</b>	<b>Age:</b>	<b>Occupation:</b>	<b>Describe Relationship With Child:</b>
Father				
Mother				
Brother (s)				
Sister (s)				
Step-Father				
Step-Mother				
Step-Brother (s)				
Step-Sister (s)				
Other				
Other				

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Describe any physical or mental illness that runs in the family including depression or suicide: \_\_\_\_\_

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Describe any abuse of substances that runs in the family: \_\_\_\_\_

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Please describe significant events in your family life that may have had an impact on your child (i.e. major moves, changes in school, divorce, loss of a loved one, abuse and/or assault of any kind, legal troubles): \_\_\_\_\_

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### Developmental History:

Please note the age at which the following behaviors took place

Weaned: _____	Dry during day: _____	Dry during night: _____	Toilet trained: _____	Fed self: _____
First words: _____	Spoke sentences: _____	Sat unassisted: _____	Crawled: _____	Took first steps: _____
Dressed self: _____	Tied shoe laces: _____	Rode two-wheeled bike: _____	First Teeth: _____	Age Entered School: _____

Please describe your child's early development. Please include any complications like feeding problems, developmental delays, colic, chronic illnesses, etc. \_\_\_\_\_

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Signature of Patient/Legal Representative

Print Name

Date

Signature of Patient/Legal Representative

Print Name

Date