

Children's/Adolescent's (6-17 years old) Psychosocial Assessment

Source of Information

- Child Interview/Observation
- Parent/Caregiver Interview
- Parent/Caregiver Self-Report form
- Prior mental health record(s)
- Standardized tests/instruments (specify) _____
- Other (list) _____

Presenting Problem

What is the presenting problem as described by the parent/caregiver. _____

Services requested by: Parent/Caregiver DHS Court PCP Other _____

Parents/Caregivers expectation for recovery: _____

History of presenting problem:

- When was this first noticed? _____
- How often is the problem occur? _____
- How severe is the problem? _____
- Context of problem: _____

Has this child been in counseling before?

- Yes No If so, please describe who, when and the results:

Is this client involved with outside agencies or service providers such as Child Welfare, DHS, Courts, School providers? Yes No

If so, please describe who, when and the results:

Strengths of Child

- Socially engaging
- Curious/interested
- Seems bright
- Is Affectionate
- Has at least one positive relationship with an adult
- Follows directions
- Shares excitement/interests with peers or adults
- Other _____

Strengths of family/caregiver(s)

- Realistic expectations for child
- Motivated to help child
- Able to tune-in to child
- Family warmth
- Support within family unit
- Effective communication
- Adequate financial resources
- Able to advocate for child
- Involved in community

Name of Responder: _____

List of Children's Behaviors: Please read the following list and rate your child on each behavior. Indicate how often your child displays that behavior by circling the number which best describes the frequency of each behavior.

Please use the following scale:	1 Never	2 Rarely	3 Occasionally	4 Frequently	5 Very Frequently
Group A 1 2 3 4 5 Has trouble sleeping 1 2 3 4 5 Has poor appetite 1 2 3 4 5 Seems sad or unhappy 1 2 3 4 5 Talks about feeling stupid or worthless 1 2 3 4 5 Loses interest in having fun 1 2 3 4 5 Seems irritable 1 2 3 4 5 Moody 1 2 3 4 5 Plays alone 1 2 3 4 5 Cries Easily 1 2 3 4 5 Seems tired			Group C (cont'd) 1 2 3 4 5 Often interrupts or 'butts in' to others' games 1 2 3 4 5 Seems disorganized loses things they need for school 1 2 3 4 5 Takes risks without considering the danger involved. (e.g., running into the street without looking) 1 2 3 4 5 Blurts out answers to questions before they have been completed.		
Group B 1 2 3 4 5 Complains of physical problems, like headaches or stomachaches 1 2 3 4 5 Worries 1 2 3 4 5 Lacks confidence in their abilities 1 2 3 4 5 Needs lots of reassurance 1 2 3 4 5 Needs to be perfect 1 2 3 4 5 Seems fearful and anxious 1 2 3 4 5 Seems shy or timid 1 2 3 4 5 Easily embarrassed 1 2 3 4 5 Sensitive to criticism 1 2 3 4 5 Bites fingernails			Group D 1 2 3 4 5 Refuses to follow rules or do chores 1 2 3 4 5 Loses temper 1 2 3 4 5 Argues with parents or teachers 1 2 3 4 5 Blames others for their 'mistakes' 1 2 3 4 5 Swears 1 2 3 4 5 Deliberately does things to annoy other people 1 2 3 4 5 Is angry or resentful 1 2 3 4 5 Carries a grudge Seems to have a chip on their shoulder 1 2 3 4 5 Touchy, easily annoyed by others		
Group C 1 2 3 4 5 Always on the go 1 2 3 4 5 Can't sit still 1 2 3 4 5 Doesn't seem to listen 1 2 3 4 5 Often fails to finish things 1 2 3 4 5 Has poor concentration and attention when it comes to school work 1 2 3 4 5 Often fidgets with hand/feet or squirms in seat 1 2 3 4 5 Easily distracted 1 2 3 4 5 Has a hard time playing quietly 1 2 3 4 5 Talks excessively			Group E 1 2 3 4 5 Steals 1 2 3 4 5 Runs away overnight 1 2 3 4 5 Lies 1 2 3 4 5 Cuts school 1 2 3 4 5 Is cruel to animals 1 2 3 4 5 Destroys property 1 2 3 4 5 Gets into fights 1 2 3 4 5 Has been physically cruel to other people 1 2 3 4 5 Doesn't seem sorry for hurting others 1 2 3 4 5 Sets fires 1 2 3 4 5 Has broken into someone else's house or car		

Substance Use History (If Applicable)

Does the child use tobacco in any form?	Current <input type="checkbox"/>	Suspected <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Does the child use alcohol?	Current <input type="checkbox"/>	Suspected <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Does the child use caffeine (any form, including cola drinks)?	Current <input type="checkbox"/>	Suspected <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Does the child use recreational drugs?	Current <input type="checkbox"/>	Suspected <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>

Medical History

Has the child seen a doctor within the last year?
 Yes No

If so, what was the reason for the visit?

Name of child's medical provider: _____

Is the child taking any medications, prescriptions, or over-the-counter medications? Yes No

If so, please list:

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any major medical problems that the child has had (chronic illnesses, serious illnesses, operations, injuries or trauma to the head?)

Does the child have any allergies?
 Yes No If so, what?

Client name: _____

Family History

- Has the child ever been homeless? Yes No
- Is there any family history of mental illness? Yes No
- Have any family members ever been affected by substance use or abuse issues? Yes No
- Has the child been away from parent for an extended period? Yes No
- Has there been family stress or family conflict? Yes No
- Has the family used community resources? Yes No

Has the child experienced trauma? (e.g., multiple or repeated events that threaten child's sense of safety: physical/sexual abuse, witness to domestic violence, severe physical neglect; Single but significant traumatic event: fire, death of caregiver/significant person, dog attack, car accident, shooting) Yes No

Please list everyone who lives at the same residence as the child.

- | | <u>Name</u> | <u>Age</u> | <u>Relationship</u> |
|----|-------------|------------|---------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

Please list family members living outside the home.

- | | <u>Name</u> | <u>Age</u> | <u>Relationship to child</u> |
|----|-------------|------------|------------------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Developmental History

Were there any problems with the pregnancy or the delivery of the child?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any problems with eating, sleeping or crying spells (colic, nightmares, etc.)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Did the child demonstrate any difficulties or delays in walking, talking, or toilet training?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have there been any family crises such as marital separation or divorce?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have there been any mental health problems in the family of origin?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have there been any substance use or abuse issues in the family?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Briefly describe the child's relationship to both parents:		
Briefly describe the child's relationship to siblings:		
Briefly describe the child's temperament:		

School History

When did the child start school?
Were there any problems when the child started school? Yes <input type="checkbox"/> No <input type="checkbox"/>
What problems have come up during the school years?
What grades is the child getting?
Describe any changes in the child's school performance:
How does the child get along with his or her teachers?
How does the child get along with his or her friends or peers in school?
What are the child's favorite subjects or school activities?
What subjects or activities does the child have problems with?