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CHILD/ADOLESCENT PSYCHOSOCIAL ASSESSMENT

Name of individual to receive services: _____

Date of Birth: _____ Sex: Social Security #: _____ ___ _____

Insurance ID #: _____

Other names used: _____

Who referred you to treatment? ☐ Self ☐ Dept. Children & Families ☐ Parents ☐ Family member ☐ Physician ☐ School ☐ Work ☐ Other, specify: _____

Who has Legal Custody of Child? _____
Name(s) and relationship(s) of persons providing assessment information: _____

Are you willing and able to participate in client services when appropriate? Yes No
Comments: _____

PRESENTING PROBLEM

Describe specifically the mental, emotional, and/or behavioral problems the Child is currently experiencing. Include how often; how long: _____

History of the problems (Describe age and circumstances when problems began):
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAST MENTAL HEALTH TREATMENT SESSION

Has the Child ever been in the hospital for mental health treatment? Yes No
Has the Child ever been in outpatient care for mental health treatment? Yes No
Has the Child ever been in an in-school treatment program? Yes No
Has the Child ever been in a residential treatment center? Yes No

Name of Facility Location Reason for Treatment Start/End Dates How did child do?
_____

Was treatment completed? Yes No
Did Child have a positive experience in previous treatment? Yes No

Was Child compliant with treatment recommendations? Yes No
Comments regarding treatment history: _____

Do you feel that the child is at risk for dangerous behaviors? Yes No
What situations increase the risk for dangerous behaviors?

What does child do to cope with these risks? _____

Describe any warning signs for the dangerous behaviors:

EDUCATIONAL HISTORY SESSION

Current school: _____ Current Grade: _____
Current daycare:_____

History of:

Academic Problems: Yes No Academic Strengths: Yes No
If yes, explain: _____
Has Child been retained? Yes No
If yes, explain:
Behavior Problems: Yes No
If yes, explain: _____
Educational Evaluations: Yes No
If yes, explain:
Special Education Placement: Yes No
If yes, explain: _____

EMPLOYMENT HISTORY SESSION

Has the Child had any Vocational training? Yes No
Describe:
Has the Child had any Vocational problems? Yes No
Describe:
Has the Child ever worked? Yes No
Describe: _____

SOCIAL RESOURCES SESSION

Is the Child able to form and maintain relationships with family/friends? Yes No
Peer relationships: _____

What are the Child's favorite activities:
_____
Hobbies and interests: _____
_____

Does the child have a Girlfriend or Boyfriend: Yes No
Current problems with close relationships? Yes No
Describe: _____

Sexually active: Yes No

Describe: _____

Gang involvement: Yes No
Describe: _____

LEGAL HISTORY OF CHILD/ADOLESCENT

If history of legal issues, please explain:

Arrest charges pending: Yes No
Describe: _____
Previous arrests: Yes No
Describe: _____
Probation: Yes No
Describe: _____
Court supervision: Yes No
Describe: _____
Family court/status offenses: Yes No
Describe: _____
Restitution: Yes No
Describe: _____

DEVELOPMENTAL HISTORY

Were there complications with the pregnancy? Yes No
Describe: _____
Did mother sustain any major injury/illness while pregnant? Yes No
Describe: _____
Did mother use tobacco, alcohol, street drugs or prescription drugs during pregnancy?
Yes No
Describe: _____
Was the delivery premature or overdue? Yes No
Describe: _____
Were the complications with the labor/delivery? Yes No
Describe: _____

DEVELOPMENT

Gross motor development: Early Average Delayed Don't Know
Fine motor development: Early Average Delayed Don't Know
Cognitive development: Early Average Delayed Don't Know
Expressive communication: Early Average Delayed Don't Know
Receptive communication: Early Average Delayed Don't Know
Self-care (e.g., dressing, feeding, toileting):
Early Average Delayed Don't Know
Social skills: Early Average Delayed Don't Know
Comments: _____
_____

MEDICAL HISTORY

What is Child's general health: Excellent Good Fair Poor
Describe: _____
Immunization Record Current? Yes No
Any significant illnesses or injuries? Yes No
Describe: _____
_____
_____
Any neuropsychological (brain) issues? Yes No
Explain any other medical issues; identify if issues are current or in the past: _____
_____
_____

TRAUMATIC EVENTS

Current or past experience of being physically abused or neglected? Yes No
List: _____
Current or past experience of being sexually abused (fondling, touching, penetration, exposure)
Yes No
Describe: _____
_____
Describe any other traumatic experience: _____
_____
_____
Has the child received services for the past abuse? Yes No
If no, would you be interested in receiving services? Yes No

CURRENT LIVING SITUATION

Is child in need of food, clothing, or shelter? **Yes No**
Describe:
_____

Current living arrangement (child lives with):
( ) Biological family ( ) Foster family ( ) Other: _____

Number of persons, other than the Child, currently living in the home: _____

Living environment (condition of the home): ( )Good ( )In need of repair
How many times has the Child's residence changed within the last two years? _____
Explain: _____

How would you rate the family's Socioeconomic Position: Well Above Average __ Above Average __Average __Below Average __Well Below Average

Do you possibly qualify for public assistance? Yes No Unknown

What are the Child's current support systems:

Describe: _____

CHILD'S STRENGTHS AND ABILITIES

List:

_____

_____

CHILD'S/FAMILY'S PREFERENCES

List: _____

PAST SIGNIFICANT EVENTS (Check any of the following that apply):

__Significant medical condition of parent/caregiver
__Medical condition of child
__Post-partum adjustment problems of mother
__Mental illness of parent/caregiver
__Substance abuse of parent/caregiver
__Separation/divorce of parent/caregiver
__Adoption
__Abandonment of significant adult caregiver
__Death of parent/caregiver
__Mental retardation of parent/caregiver
__Incarceration of parent/caregiver

Comments: _____

_____

_____

Has the Child ever lived in any of the following settings? Yes No

__Relative's home __Foster family __Orphanage
__Group home __Therapeutic foster care __Halfway house
__Emergency shelter __Correctional facility __Residential substance abuse facility
__Detention facility __Homeless __Hospital
__Other __Residential treatment center

Comments: _____

Most restrictive living situation in last 3 months:

_____

SPIRITUAL CONSIDERATIONS

Primary religious affiliation: _____

If Christianity, does the family attend a church? _____ Where? _____

_____

How often does the family attend church services?

( ) weekly ( ) monthly ( ) seldom ( ) never

What helps the child/family grow closer to God (i.e. prayer, Bible study, Sunday School):

_____

FAMILY HISTORY	
Has any **family member** had a history of Mental Illness: Yes No If so, describe illness (give diagnosis if known): _____ _____ Family History of Substance Abuse? Yes No If yes, describe: _____ _____ Family History of Criminal Activity? Yes No If yes, describe: _____ _____ Family History of Violent Behavior? Yes No If yes, describe: _____ _____ Family History of Medical Problems? Yes No If yes, describe: _____ _____	

BIOPSYCHOSOCIAL

Please check those that apply to the client and fill in examples in the boxes below the symptoms.

1. Feeling / Mood / Affect

Problem Areas:

Mood liability__ Coping Skill __Suicidal/homicidal ideation/plan__

__Depression __Anger __Anxiety __Euphoria __Change in appetite/sleep patterns

Evidenced by (specific examples, symptom frequency, duration and intensity):

2. Thinking / Mental Process

Problem Areas:

__Memory __Cognitive process __Concentration __Judgment __Obsessions

__Delusions/hallucinations __Belief system __Learning disabilities __Impulse Control

Evidenced by (specific examples, symptom frequency, duration and intensity):

3. Substance Use

Drug of Choice	Amount Used	Frequency of Use	First Used	Last Used

Functional impact of current use, examples of level of dependency:

4. Medical / Physical Health

Current medical/physical conditions:

Impact/limitations on day-to-day function:

Medications (Name of Rx, Dosage/Frequency, Reason for Rx):

NAME	DOSAGE	REASON	ACTIVE/INACTIVE?	EXPIRY DATE

5. Family

Problem Areas:

__Parenting __Conflict __Abusive/violence __Communication __Marital

__Sibling __Parent/child __Other: _____

Evidenced by (specific examples, symptom frequency, duration and intensity):

6. Interpersonal

Problem Areas:

__Peers/Friends __Social Interaction __Withdrawal __Make/Keep Friends __Conflict

Evidenced by (specific examples, symptom frequency, duration and intensity):

7. Role Performance

Problem Areas:

__Employment/Volunteer __School/daycare __Home management __Other: _____

Effectiveness of functioning in identified role:

Evidenced by (specific examples, symptom frequency, duration and intensity):

8. Socio-Legal Issues

Problem Areas:

__Ability to follow rules/laws __Authority issues __Legal issues __Aggression

__Probation/parole __Abides by personal ethical/moral value system __Antisocial behaviors

Evidenced by (specific examples, symptom frequency, duration and intensity):

Probation/Parole Officer: _____

DHS Worker:

9. Self-Care / Basic Needs

Problem Areas:

__Hygiene __Food __Clothing __Shelter __Medical/Dental __Transportation

__Personal Mobility __Communication __Hearing __Vision

Evidenced by (specific examples, symptom frequency, duration and intensity):

Consumer expectations/goals for treatment (What changes would you like to make or see?)

Consumer strengths and abilities:

Consumer needs and preferences for treatments:
