Child/Adolescent INITIAL ASSESSMENT

Child Name: _____ Date: _____
Other attendees/relationship: _____
_____
Child's DOB: _____ Age:_____ Gender: __ Preferred phone number: _____
School and Grade: _____Child cell phone:_____

1. What brings you here today?

2. Any previous counseling? If yes, where and when.

3. Family
Who is in your family? Parents/siblings/grandparents. Names and ages. Indicate if deceased

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4. Health
Last physical exam _____ Doctor's name _____
Medical history (illnesses, accidents, medications, current health status)

Any developmental delays?
Pregnancy/birth problems? Smoking, alcohol or drug use during pregnancy?

Is your child on any Medications?

Does your child use alcohol? Cigarettes? Drugs?

Family health history:

Family mental health history (depression, anxiety, ADHD, suicide, etc):

5. Personal
Any changes or losses in your child's life?

Child's Employment history:

Highest education level: Grades: Any school issues?

Does your child have an IEP (individual education program)?

School contact:

Any legal issues?

Has your child experienced or witnessed any abuse?: Yes or No. Physical, Emotional or Sexual

Has your child experienced any traumatic events? (tornadoes, violence, accidents)

Who/what is your child's support system?

What are your child's strengths?

What does your child do for fun?

What are the goals for coming here? What would you like to see change in your child's life?

Current Health Concerns: Please circle where you think your child may have a problem.
Headaches Depression *Breathing* Anger/Temper *Circulation* Frequent Mood Changes *Indecision*
Bowel Function *Self Concept* Tiredness *Guilt* Urinary Function *Suicide Ideas* Sexuality
Problems with Relatives *Smoking* Alcohol Use *Memory* Weight loss/gain *Interpersonal Relations*
Stomach Problems Menstrual Cycle *Parenting Concerns* School Problems *Work/Job Issues*
Marital Issues *Phobias* Concentration *Attention* Eating/Appetite *Anxiety/Worry* Drug Use *Chronic Pain*
Joint/Muscle Function Skin Condition *Sleep Disturbance* Other_____

Anything else important for us to know in order to help you?

Thank you!!

Behavioral Observations (check boxes and note any specific observations below each)

Appearance: □ Normal □ Tidy □ Disheveled □ Immature □ Unclean □ Unusual □ Dysmorphic

Eye contact: □ Good □ Culturally appropriate □ Adequate □ Inconsistent □ Overly intense □ Poor

Energy Level: □ Normal □ Hyperactive □ Lethargic □ Fluctuating □ Agitated/restless

Speech: □ Normal □ Nonverbal □ Halting/difficulty finding words □ Rapid □ Loud
□ Quiet □ Slowed □ Monotone □ Impoverished □ Peculiar topics/other □ Stuttering

Affect: □ Composed □ Tearful/sad □ Distressed □ Euphoric □ Labile □ Angry □ Shallow
□ Apathetic □ Anxious □ Blunt/flat □ Suspicious □ Inconsistent with thought/speech □ Dramatic
Gait/Gross Motor Movement: □ Normal □ Accelerated □ Slowed/retarded □ Stiff/Rigid
□ Clumsy/lacking coordination □ Exaggerated □ Peculiar

Posture: □ Normal □ Slumped □ Rigid □ Atypical

Mannerisms: □ None noted □ Tics □ Rocking □ Grimacing□ Fidgety □ Tugging
□ Flapping □ Tremors □ Other

Cognitive Observations (check boxes and note any specific observations below each)

Consciousness: □ Alert □ Drowsy/dazed □ Easily startled □ Fluctuating □ Confused
□ Unresponsive □ Under-responsive

Attention: □ Good □ Distractible □ Selective □ Inadequate □ Pre-occupied

Orientation: □ Normal Impaired orientation to: □ Person □ Place □ Time □ Situation

Memory: □ Intact □ Impaired STM □ Impaired LTM □ Impaired immed. Recall □ Adeq. recall w/effort

Intellectual Functioning: □ Average □ Below Average □ Above Average Any known deficits: □ Verbal □ Non-verbal

Thought Content: □ Unremarkable □ Obsessions □ Pre-occupation □ Delusions

Thought Process: □ Unremarkable □ Non-linear □ Delusions □ Loose associations □ Paranoia □ Rapid shifts of focus
□ Narcissism □ Somatic pre-occupations □ Obsession □ Grandiosity □ Other (specify)

Perceptual Disturbance: □ None □ Flashbacks □ Dissociation
Hallucinations: □ Visual □ Auditory □ Tactile □ Olfactory

Insight: □ Developmentally appropriate □ Denies Problem □ Projects blame □ Poor
Judgment: □ Dev. appropriate □ Unsafe behavior □ Inflexible □ Easily overwhelmed
□ Poor decision-making

Risk Assessment
Suicide risk: □ Denies □ Ideation □ Intent □ Plan □ Attempt
Notes:

Danger to others: □ Denies □ Ideation □ Intent □ Plan □ Attempt
Notes:

Diagnostic Impressions
Preliminary diagnosis: Axis I
Axis II
Axis III
Axis IV
Axis V

Goals:

Frequency of session/expected length of treatment:

Treatment modality:

Client Signature:_____Date:_____

Parent/Guardian:_____Date:_____

Therapist signature: _____ Date: _____

REVIEW DATE: _____
3 months or 6 sessions, whichever is longer