CHILD/ADOLESCENT PSYCHOSOCIAL ASSESSMENT

Date of appointment: _____ **Time of appointment:** _____

Client Name: _____ **Age:** _____ **DOB:** _____

Gender: ☐ Male ☐ Female ☐ Transgender **Preferred Name/Nickname:** _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** _____

Name of Person completing form: _____ **Relationship to client:** _____

PRESENTING PROBLEM: (Briefly describe the issues/problems which led to your decision to seek therapy services).

How severe, on a scale of 1-10 (with 1 being the most severe)**, do you rate your child's presenting problems?**

PRESENTING PROBLEM CATEGORIZATION: (Please check all the apply and check the description of symptom)

Symptoms causing concern, distress or impairment:

☐ **Change in sleep patterns** (*please check*): ☐ sleeping more ☐ sleeping less ☐ difficulty falling asleep ☐ difficulty staying asleep ☐ difficulty waking up ☐ difficulty staying awake

☐ **Concentration:** Decreased concentration Increased or excessive concentration

☐ **Change in appetite:** Increased appetite Decreased appetite

☐ **Increased Anxiety** (describe): _____

☐ **Mood Swings** (describe): _____

☐ **Behavioral Problems/Changes** (describe):

_____

☐ **Victimization** (*please check*) ☐ Physical abuse ☐ Sexual abuse ☐ Psychological Abuse ☐ Robbery victim ☐ Assault victim ☐ Dating violence ☐ Domestic Violence ☐ Human trafficking ☐ DUI/DWI crash ☐ Survivors of homicide victims

Other: _____

Other (Please describe other concerns): _____

_____

How long has this problem been causing your child distress? (pleasecheck)

☐ One week ☐ One month ☐ 1 – 6 Months ☐ 6 Months – 1 Year ☐ Longer than one year

How do you rate your child's current level of coping on a scale of 1 – 10 (with 1 being unable to cope)**?**

_____

FAMILY COMPOSITION:

Mother's Name: _____ Age: _____

☐ Living with child ☐ Not living with child Employed Currently? ☐ Yes ☐ No

Place of Employment: _____ Occupation: _____

Father's Name: _____ Age: _____

☐ Living with child ☐ Not living with child Employed Currently? ☐ Yes ☐ No

Place of Employment: _____ Occupation: _____

Marital status of Parents: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in- or outside the home. Please include all members currently residing in child's household.

Name	Gender	Age	Relationship To Client	Living With Child
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

What else do you feel/believe would be helpful, or important for the team at Apple Tree Counseling to know/ understand about your relationships with your family or about your family members?

RECENT LOSSES:

☐ Family Member ☐ Friend ☐ Health ☐ Lifestyle ☐ Job ☐ Income ☐ Housing ☐ None

Who? _____ When? _____ Nature of Loss? _____

Other Losses: _____

Additional information (if needed):

PREGNANCY & BIRTH HISTORY:

Were there any complications during pregnancy? ☐ Yes ☐ No If yes, please explain: _____

☐ Full-term Birth ☐ Premature Birth

Were there any complications during birth? ☐ Yes ☐ No If yes, please explain: _____

Were drugs or alcohol consumed during pregnancy? ☐ Yes ☐ No

Child's weight at birth? _____ lbs. _____ oz. **Child's health at birth?** _____

Length of hospital stay? _____ **Post-partum depression?** ☐ Yes ☐ No

Was your child adopted? ☐ Yes ☐ No If yes, at what age? _____

☐ Domestic adoption ☐ International adoption (Country: _____)

DEVELOPMENTAL HISTORY:

As accurately as you can remember, how old was your child when she/he:

Rolled over? _____ **Crawled?** _____ **Walked?** _____ **Talked (two words)?** _____ **Toilet Trained?** _____

Do/did you have concerns about your child's development in any of these areas (below)?

☐ Speech/Language ☐ Motor Skills ☐ Cognitive/Intellectual ☐ Sensory ☐ Behavioral ☐ Emotional ☐ Social

If so, please describe: _____

Were there any significant disturbances/changes during your child's childhood? ☐ Yes ☐ No

If yes, please describe:

HEALTH HISTORY

How would you describe your child's overall health? _____

Does your child have any health issues? ☐ Yes ☐ No If yes, please list below: _____

Does your child have any recurrent medical conditions such as ear infections, asthma or allergies? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have tubes in his/her ears? ☐ Yes ☐ No

Include current significant medical problems, physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc.)

Medical Conditions	Currently receiving treatment?	Provider	Does this condition cause stress or impairment at this time?	What have you found that helps?

Does your child take any medications? ☐ Yes ☐ No

Please list medications (including psychotropic, over-the-counter, herbal remedies) that you have taken in the past 6 months

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

Is your child taking the medications as prescribed? ☐ Yes ☐ No If No, please explain: _____

Additional information (if needed): _____

Has your child ever had a serious accident/illness or hospitalization? ☐ Yes ☐ No

Please list all past hospitalizations, surgeries, accidents, or illnesses in the chart below.

Reason for Previous Hospitalizations, Accident, Illness	Date/Location of Hospitalization

Has your child had the following screenings (please check all that apply)?

☐ Hearing Screening Date: _____ Outcome: _____

☐ Vision Screening Date: _____ Outcome: _____

☐ Speech/Language Screening Date: _____ Outcome: _____

Primary Care Doctor: _____ Facility: _____ Phone Number: _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Is your child currently being seen by a counselor? ☐ Yes ☐ No

If yes, name of current counselor _____ Length of Treatment _____

Is your child currently being seen by a psychiatrist? ☐ Yes ☐ No

If yes, name of current psychiatrist _____ Length of Treatment _____

Has your child ever been diagnosed with a mental health, emotional or psychological condition?

☐ Yes ☐ No

If yes, what diagnosis was your child given? _____

When? _____

By Whom? _____

Has your child received counseling services or been hospitalized for mental health or drug and alcohol concerns in the past? ☐ Yes ☐ No

If yes, please list previous counseling/hospitalizations for mental health/drug and alcohol concerns below

Dates of Service	Place/Provider	Reason for treatment	Were the services helpful

Additional information: _____

SAFETY CONCERNS:

Is your child presently suicidal? ☐ Yes ☐ No If Yes, please explain _____

Has your child ever attempted to commit suicide? ☐ Yes ☐ No If yes, when and how? _____

Is there a history of suicide in your child's immediate and/or extended family? ☐ Yes ☐ No

If Yes, please explain

Has your child ever inflicted burns or wound on his/herself? ☐ Yes ☐ No

Is your child presently homicidal? ☐ Yes ☐ No If yes, please explain

Additional Information: (please list additional information as needed to address past and current safety issues)

CURRENT FUNCTIONING:

Do you have concerns about your child in the following areas? (check all that apply)**?**

☐ Eating ☐ Hygiene/grooming ☐ Sleeping ☐ Activities/play ☐ Social Relationships

If so, please describe:

Please rate your child's personality/temperament (how they behave the majority of the time in each of the following areas on a scale from 1 to 7 by placing a check above the number that best describes your child):

ENERGY/ACTIVITY LEVEL (how active is my child?)

CAN sit still and listen for long periods of time ☐ 1 : ☐ 2 : ☐ 3 : ☐ 4 : ☐ 5 : ☐ 6 : ☐ 7 **CAN'T** sit still and listen for long periods of time

NEED FOR PHYSICAL ROUTINE (how much routine does my child need)?

ENJOYS ROUTINE; easily upset when day doesn't go as usual ☐ 1 : ☐ 2 : ☐ 3 : ☐ 4 : ☐ 5 : ☐ 6 : ☐ 7 **ENJOYS DOING THINGS DIFFERENTLY**; may not notice small changes in the day

MOOD (what is my child's mood most of the time)?

ANXIOUS-usually frustrated and worried ___: ___: ___: ___: ___: ___: ___ **CALM**-usually relaxed
1 2 3 4 5 6 7

HAPPY-usually enjoys what he/she is doing ___: ___: ___: ___: ___: ___: ___ **SAD**-usually unhappy; hard time having fun
1 2 3 4 5 6 7

CURIOUS-usually eager to know something ___: ___: ___: ___: ___: ___: ___ **TIMID**-usually not interested
1 2 3 4 5 6 7

ANGRY-easily frustrated and annoyed with others ___: ___: ___: ___: ___: ___: ___ **CALM**-usually composed and peaceful with others
1 2 3 4 5 6 7

INTENSITY (how strongly does my child express feelings, wants and opinions?)

MILD REACTION-calm and cooperative; Easily pushed around by others ___: ___: ___: ___: ___: ___: ___ **STRONG REACTION**- may cry or yell over small things
1 2 3 4 5 6 7

PERSISTENCE (Can my child stick with and complete tasks?)

Will stick with something until it is done ___: ___: ___: ___: ___: ___: ___ **Gives up on tasks**; has trouble finishing things
1 2 3 4 5 6 7

SENSITIVITY TO SENSES (How sensitive is my child to light, smells, sounds, and touching?)

Learns by seeing touching and using all his/her senses ___: ___: ___: ___: ___: ___: ___ **Has strong reaction** to noise, lights, hugging or touching
1 2 3 4 5 6 7

PERCEPTIVENESS (How aware is my child of feelings and emotions?)

Sympathetic to others; can use words to tell how he/she feels ___: ___: ___: ___: ___: ___: ___ **Unaware** of the feelings of others
1 2 3 4 5 6 7

ADAPTABILITY (How easily does my child accept changes?)

Often fearful with new people and new situations ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 **Will easily meet** and accept new people and activities

ATTENTION SPAN/DISCTRACTIBILITY (How well does my child pay attention?)

Stays focused on tasks until completed ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 **Easily sidetracked**; difficulty following directions

PARENT/CHILD RELATIONSHIP

Describe parenting your child (e.g. challenging, easy):

What do you find most challenging in parenting your child?

What kind of discipline works best with your child?

EDUCATION

Is your child currently enrolled in school? ☐ Yes ☐ No **Name of School**

What grade is your child currently in (if summer, was grade is your child going into)?

How would you describe your child's attendance (currently)? (check ALL that apply)

☐ Attending regularly ☐ Home-schooled ☐ Some truancy ☐ Alternative school ☐ Suspended

☐ Expelled ☐ Dropped Out ☐ GED program

How would you describe your child's achievement/grades in school?

How would you describe your child's attitude towards school/education?

Disciplinary or behavioral issues at school? ☐ Yes ☐ No **If yes, describe:**

Please check if your child has any of the following?

☐ **Special Education Accommodations or a 504? Please describe:**

☐ **An Individualized Education Plan (IEP)? Please describe:**

☐ **Diagnosed Learning Disability? Please describe:**

☐ **Receiving special services at school? Please describe:**

EMPLOYMENT:

Is your child currently employed? ☐ Yes ☐ No

If employed, where are they working? _____ **How long?** _____

Does your child enjoy their current job? ☐ Yes ☐ No

HOUSING:

Would you consider your housing to be: ☐ **stable** ☐ **unstable** **If unstable, please describe:** _____

_____

Please choose the one that best describes the current housing arrangement for this child:

☐ Parent/Guardian owns home
☐ Parent/Guardian rents home
☐ Child and family live with relatives/friends (temporary)
☐ Child and family live with relatives/friends (permanent)
☐ Homeless ☐ Transitional Housing ☐ Emergency Shelter

How long has this child lived in the current living situation? _____

How many times has the child moved in the past two years? _____

What else do you think is important for us to understand about your housing/living situation?

_____

FOSTER CARE INVOLVEMENT:

Has your child ever been in foster care? ☐ Yes ☐ No ☐ Unknown

From _____ age to _____ age Reason: _____

Type of Placement: ☐ Familial Placement ☐ Non-Familial Placement

Current Status: ☐ In-Care ☐ Out of Care

If Out of Care, reason for leaving: ☐ Adopted ☐ Returned to Home ☐ Emancipated
☐ Ran away from care ☐ Other: _____

FAMILY MENTAL HEALTH HISTORY

Please identify if any members of your family have had a history of any of the following mental health/drug abuse/legal concerns.

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Self	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Biological Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional Information:

ALCOHOL/DRUG ASSESSMENT:

Does your child use tobacco or smokeless tobacco? ☐ Yes ☐ No ☐ Do not know

Does your child use alcohol or drugs? ☐ Yes ☐ No ☐ Do not know

To your knowledge, has your child ever used medications (prescriptions drugs or over the counter medication) recreationally? ☐ Yes ☐ No ☐ Do not know

To your knowledge, has your child ever overdosed or passed out on alcohol or other drugs?

Yes No If yes, when was the last overdose? _____

Has your child ever experienced problems related to their alcohol use? Yes No

If yes, please check area and describe problems:

Legal Social/Peer Work Family Friends Financial

Please describe: _____

If yes, have they continued to drink/use drugs? Yes No

LEGAL INVOLVEMENT:

Is there a current custody case involving your child? Yes No If yes, please describe below.

History of CPS involvement: None Past Current Please describe below.

Please indicate by checking your child's legal status below.

No Involvement No Involvement Probation | Length: _____

Parole | Length: _____ Charges Pending Prior Incarceration

Law Suit or other Court Proceeding

Charges: _____ Probation/Parole Officer's Name: _____

Contact #: _____

Additional Information: _____

HISTORY OF ABUSE/NEGLECT:

Has your child ever been abused or assaulted? Yes No If Yes, please complete the chart below.

Type of Abuse	By Whom? (relation to child if any)	At What Age?	Was it Reported?
Sexual			Yes No
Physical			Yes No
Emotional			Yes No
Verbal			Yes No
Abandoned/Neglected			Yes No

Has your child ever been a victim of bullying? Yes No

Do you worry about your child's safety now? Yes No

What else do you feel is important for us to know?

HISTORY OF VIOLENCE:

Has your child ever been accused of abusing or assaulting someone? Yes No If yes, please complete chart below.

Type of Abuse	To Whom?	Age of your child?	Was it Reported?
Sexual			Yes No
Physical			Yes No
Emotional			Yes No
Verbal			Yes No
Abandoned/Neglected			Yes No

Has your child ever been known to bully other children? Yes No

What else do you feel/believe is important for us to know?

STRENGTHS/RESOURCES/SUPPORTS:

What limitations does your child/ family have (if any)?

What strengths does your child/family have?

What resources does your child have to help with your current problem?

What experiences (past & present) will help you in improving the current situation?

What are you (and your family) already doing to improve the current situation?

Who does/can your child count on for support? Parents Boyfriend/Girlfriend Siblings Extended Family Friends Neighbors School Staff Church Pastor Therapist Group Community Services Doctor Other:

CURRENT NEEDS/GOALS

What do you feel is your child's biggest need right now? _____

What do you most hope to gain from coming to counseling? _____

If you were to pick three goals to work on, what would they be?

Goal 1: _____

Goal 2: _____

Goal 3: _____

What else would you like for the team at Apple Tree Counseling, LLC to be aware of?

INDIVIDUAL(S) COMPLETING ASSESSMENT

Printed Name (primary person) _____ **Date:** _____

Signature _____

Relationship to child _____

Printed Name (secondary person) _____ **Date:** _____

Signature _____

Relationship to child _____