

# Susan Dellutri, LLC

## Child & Adolescent Health & Psychosocial Assessment

To be completed by the parent or guardian.

Child's name \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Form Completed by [ ] Self [ ] Other \_\_\_\_\_  
Accompanied by \_\_\_\_\_/Relationship \_\_\_\_\_ Referred by \_\_\_\_\_

### REASON FOR SEEKING TREATMENT:

\_\_\_\_\_  
\_\_\_\_\_

GOALS YOU WOULD LIKE ACHIEVED IN TREATMENT: \_\_\_\_\_

\_\_\_\_\_

Where does the problem occur: Home School Community

Age when problem began: \_\_\_\_\_ Duration: Less than 6 months Greater than 6 months

Child's Strengths and Limitations: \_\_\_\_\_

\_\_\_\_\_

### SOCIAL HISTORY:

Current school, grade, teacher \_\_\_\_\_

Special Programming (M teams, IEP, etc.) \_\_\_\_\_

Social/psychological services: \_\_\_\_\_

Academic Functioning: Present \_\_\_\_\_

Past History \_\_\_\_\_

Behavior in School: Present \_\_\_\_\_

Past History \_\_\_\_\_

Juvenile Court Contacts: None Yes (Please Explain) \_\_\_\_\_

\_\_\_\_\_

### SAFETY

Has your child had any suicidal/self-harmful thoughts recently (in the past month)? [ ] Yes [ ] No

Has your child ever had any suicidal thoughts? [ ] Yes [ ] No

Has your child ever made a suicide attempt? [ ] Yes [ ] No

Has any immediate family or "extended family" (i.e. aunts, uncles, cousins, grandparents) or close friends ever attempted suicide? [ ] Yes [ ] No Completed suicide? [ ] Yes [ ] No

If yes to any of the above, please explain \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

**MEMBERS OF HOUSEHOLD**

Name	Age	Occupation	Relationship
_____			
_____			
_____			
_____			

**ADDITIONAL SIGNIFICANT FAMILY MEMBERS**

Name	Age	Occupation	Relationship
_____			
_____			
_____			

**PRIOR OUTPATIENT AND/OR INPATIENT MENTAL HEALTH OR CHEMICAL DEPENDENCY TREATMENT FOR PATIENT OR IMMEDIATE FAMILY MEMBERS**

Who	Where	When	Reason	Out Patient	In Patient
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]

Extended family history of mental health or drug/alcohol problems. [ ] Yes [ ] No

Comments:

Please describe any significant stresses affecting your child/family at the present time. \_\_\_\_\_

**DRUG/ALCOHOL HISTORY**

Does your child have any history of drug, alcohol, or cigarette use? [ ] Yes [ ] No (Please Explain) \_\_\_\_\_

**ABUSE ASSESSMENT**

Has your child ever been...		
Yes	No	Explain any "Yes" replies
[ ]	[ ]	Physically abused
[ ]	[ ]	Emotionally abused
[ ]	[ ]	Sexually abused
[ ]	[ ]	Sexually assaulted (rape)
[ ]	[ ]	Verbally abused
[ ]	[ ]	Exposed to family domestic violence
[ ]	[ ]	Abusive to self (cutting, burning self)

Has this been reported?  Yes  No If yes, to whom?

Does your child have a history of physical, emotional, sexual, or verbal abuse towards others?  Yes  No Explain:

### DEVELOPMENT HISTORY

Mother's health during pregnancy: \_\_\_\_\_

Parental use of drugs, alcohol, or cigarettes during pregnancy:  Yes  No

Prenatal Care:  Yes  No Postnatal Care:  Yes  No

Complications during pregnancy or delivery: \_\_\_\_\_

Health problems noted at birth: \_\_\_\_\_

Full term:  Yes  No

Did or does your child have any of the following:

Delayed Sitting Up:  Yes  No Speech Delay:  Yes  No Delayed Walking:  Yes  No

Coordination Difficulties:  Yes  No Bed Wetting:  Yes  No

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

Please comment on the following regarding your child:

Appetite:  Good  Poor

Sleep Patterns:  Normal  Abnormal (Explain) \_\_\_\_\_

Peer Relationships:  Good  Poor

Activity level:  Inactive  Average  Over Active

How do you nurture your child? \_\_\_\_\_

How do you discipline your child? \_\_\_\_\_

### **SPIRITUALITY**

Do you have a religious preference?  Yes  No (If yes, please describe) \_\_\_\_\_

Is your spiritual belief system part of your support system?  Yes  No

Do you have any spiritual concerns that you or your child would like to address in therapy?  Yes  No

### **CULTURAL**

Are there any cultural issues/customs related to your family, which your therapist should be aware of?  Yes  No

Please explain: \_\_\_\_\_

Are there any cultural expectations, values, or pressures causing conflict in your life?  Yes  No

Please explain: \_\_\_\_\_

**MEDICAL HISTORY:**

**Pediatrician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Clinic address:** \_\_\_\_\_

**Last visit** \_\_\_\_\_ **Reason for visit** \_\_\_\_\_

**Please check if your child/teen is currently experiencing or has ever experienced:**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Abnormal blood pressure  | <input type="checkbox"/> Epilepsy/Seizure          | <input type="checkbox"/> HIV Positive/AIDS/ARC      | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Acne                     | <input type="checkbox"/> Fainting Spells           | <input type="checkbox"/> Irritable Bowel Syndrome   | <input type="checkbox"/> Tumors                |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Kidney or Bladder Problems | <input type="checkbox"/> Ulcers/Abdominal Pain |
| <input type="checkbox"/> Arthritis/ Rheumatism    | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Venereal Disease      |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Head injury                | <input type="checkbox"/> Memory Loss           |
| <input type="checkbox"/> Broken Bones             | <input type="checkbox"/> Hearing Impaired          | <input type="checkbox"/> Neurological Disorders     | <input type="checkbox"/> Visual Problems       |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Hepatitis Type A, B, or C | <input type="checkbox"/> Rheumatic Fever            | <input type="checkbox"/> Weight Changes        |
| <input type="checkbox"/> Changes in appetite      | <input type="checkbox"/> Heart (Disease/Surgery)   | <input type="checkbox"/> Sickle Cell Disease        | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Skin Disorders             |  |
| <input type="checkbox"/> Diabetes                 |  | <input type="checkbox"/> Stomachaches/problems      |  |
| <input type="checkbox"/> Eating Disorders         |  |   |  |

**Does your child have any allergies**  Yes  No (Explain) \_\_\_\_\_

**Does your child have any history of problem reactions to medications**  Yes  No (Explain) \_\_\_\_\_

**Other significant health history or hospitalization:** \_\_\_\_\_

**Has your child had any significant absences due to medical problems?**  Yes  No

**Current medications:**

Current Medication	Dosage	Frequency	Prescribing Doctor	Any Side Effects

**May we contact the child's primary physician?**  Yes  No  Don't have a physician

**Additional Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parent Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Therapist Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_