Therapies East Associates, LLP

Child & Adolescent Health & Psychosocial Assessment

To be completed by the parent or guardian.

Child's name_____ Age: _____ DOB:_____
Date: _____ Sex:_____ Race:_____ Form Competed 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:

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

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:_____