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Child Assessment
Biographical Information and Symptom Description

Please fill this form out as completely as possible. It will help me with the assessment. If you wish you can either e-mail it to me or you can bring it with you to our first session. If you feel uncomfortable answering a question that's ok. Just write "Do not care to answer" in the space provided.

Date: _____

Child's Name: _____
Last First Middle

Date of Birth: _____ Age: _____ Gender: _____

Address: _____
Street City State Zip

School & Grade: _____

Emergency Contact other than primary parent/guardian(s):

Name:_____ Phone :_____

Who referred you?:_____

Who has legal rights to make medical & educational decisions for your child?
Please provide any relevant court documentation regarding physical/legal custody if relevant.

Cultural background information. *Please describe relevant cultural information including ethnic background, religious affiliation, family values, important customs/traditions, languages spoken in the home, and community groups/participation.*

PARENT/GUARDIAN INFORMATION

Adult 1 Name: _____Relationship:_____

Phone Number:_____ Email: _____

Is it ok to leave confidential/private messages at the phone number provided? Yes / No

Adult 2 Name: _____Relationship:_____

Phone Number: _____ Email: _____

Is it ok to leave confidential/private messages at the phone number provided? Yes / No

MEDICAL HISTORY OF THE CHILD

Pediatrician: *Name and phone number*

Other Medical doctors / specialists: *Names and phone numbers*

Date of last physical exam:_____

Please tell me about any major medical conditions, surgeries, accidents, or illnesses.

List ***all*** medications your child is currently taking. Include dosages and reason for taking.

Family Medical History: *Please list any medical illnesses that run in the family*.

Please indicate if your child has experienced any of the following:

Symptom	Yes / No	If 'yes', what age?
Severe headaches		
Head injury		
Fainting spells		
Seizures or convulsions		
Vision problems		

Hearing impairment		
Difficulty with speaking		
Heart disease		
Difficulty with sleeping		
Abrupt weight gain/loss		
Asthma		
Frequent diarrhea/constipation		
Frequent nausea/vomiting		
Episodes of prolonged high fever		
Bedwetting		
Soiling self		
Operations / Surgeries		
Allergies (medication, food, pollen, etc)		

CURRENT SYMPTOMS / CONCERNS

What is your major area of concern?

Please place a check next to current concerns / symptoms.

___Headache ___Stomach aches ___Nightmares ___ Weight Change

___ Bowel trouble ___ Grief/Loss ___ Binge eating ___ Muscle aches

___ Withdrawn ___ Anxiety/Worry ___ Fears ___ Sad / Hopeless

___Trauma ___Low self-esteem ___ Foster/Adopted ___ Refusal to share

___Sleep problems ___Frequent tantrums ___Panicky ___Always tired

___Hyperactive ___Experienced trauma ___Social concerns ___Divorce/Separation

___School issues ___Developmental delays ___Aggression ___Disobedient

___ Risk taking ___ Self-harm ___ Suicidal thoughts or actions

___Sexualized play ___Denies affection from parents ___Separation Anxiety

___Acts older/younger than age ___Adjustment difficulty ___ Communication difficulty

How long have you observed these symptoms?

DEVELOPMENTAL HISTORY OF THE CHILD

Pregnancy

Was the pregnancy planned? Yes / No

Were there any problems during pregnancy? Yes / No
If yes, please describe.

Were drugs or alcohol used during the pregnancy? Yes / No
If yes, please describe type, amount, and frequency.

Please describe any stressors or complications with the pregnancy.

Labor and Delivery

Weight:_____ AGPAR: _____ Who was present at delivery:_____

Were there any complications with the labor or delivery? Yes / No
If yes, please describe.

How long was the biological mother in labor for?

Was your child premature or overdue? Yes / No
If yes, please describe.

Were there any irregularities in your child's appearance or behavior at birth or during infancy? Yes / No *If yes, please describe*.

Infancy

Did the mother experience postpartum psychiatric problems (ie. depression)? Yes / No

How would you describe your child as a baby?
Example: friendly or shy, easy or difficult to care for, happy or fussy, etc.

Milestones

At what age did your child first *(answer in months)*:

Social smile:_____ Selective Smile:_____

Sleep through the night:_____ Roll over: _____

Crawl: _____ Walk: _____ Feed self: _____

Talk. Babbling: _____ Words: _____ Sentences: _____

Toilet Trained. Bladder: _____ Bowel: _____

Please describe any developmental concerns regarding your child.
Include concerns about language/communication, motor functioning, adaptive functioning (self-help/toileting), cognitive functioning (attention/exploration/problem-solving), and social/emotional functioning.

Compared with other children, was your child's development fast, slow, or normal?

Was this child: _____easier _____the same _____harder to raise than others?

FAMILY SYSTEM REVIEW

Who lives in the home? What is the size of the house and how long have you lived there?

Sibling names and ages:

Describe the relationship with extended family members:

Family social support. *Include community activities & affiliations*

Describe the family history of psychiatric, legal/criminal, and alcohol/drug concerns.

Has CPS ever been involved with your family? Has your child ever been placed out of the home?