Child Intake/Psychosocial Assessment Form

Name of parent/guardian

Last name	First name	Middle Initial

Address of parent/guardian

Address _____

City	State	Zip

Home phone	May we leave a message? ___ Yes ___ No
Cell/other phone	May we leave a message? ___ Yes ___ No
Email	May we email you? ___ Yes ___ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Name of insurance policy holder _____ (Last) _____ (First)

Relationship to Child _____

Address of insurance policy holder
Address 1 _____
Address 2 (optional) _____
City _____ State _____ Zip _____

Please provide the following information about your child:

Child's Full Name _____ Nick Name _____

Insurance Plan Name:_____ Member ID:_____

Child's cell phone _____ May we leave a message? ___ Yes ___ No

Child's birth date _____ **Today's date** _____

Behavioral History

Behavioral Excesses

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets

What does your child do that you like? What does he/she do that other people like?

Others Concerns

Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

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?**

MOST SEVERE 1 2 3 4 5 6 7 8 9 10 LEAST SEVERE

PRESENTING PROBLEM CATEGORIZATION: (Please check all that apply and circle the description)

Symptoms causing concern, distress or impairment:

☐ **Change in sleep patterns** (*please circle*): 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 circle)*: Physical abuse Sexual abuse Psychological Abuse

Robbery victim Assault victim Dating violence Domestic Violence

Human trafficking DUI/DWI crash Survivor of homicide victims

Other: _____

Other (Please describe other concerns): _____

_____

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

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)?

UNABLE TO COPE 1 2 3 4 5 6 7 8 9 10 ABLE 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 a 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 us 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:

_____

_____

_____

Family History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.

	Yes	No	List Family Member if Yes
Alcohol/Substance Abuse	_____	_____	
Anxiety	_____	_____	
Depression	_____	_____	
Domestic Violence	_____	_____	
Eating Disorders	_____	_____	
Obesity	_____	_____	
Obsessive Compulsive Behavior	_____	_____	
Schizophrenia	_____	_____	
Suicide Attempts	_____	_____	

Is your family spiritual or religious? ___No ___Yes If yes, please describe your faith or belief:

_____

Education History

What school does your child attend?

Address:

Phone:_____ Teacher's Name:_____

Current Grade:_____

What does your child's teacher say about him/her?

Other schools attended (including pre-school)

Has your child ever repeated a grade? If so, which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at school?

___ fighting ___ lack of friends ___ drug/alcohol

___ detention ___ suspension ___ learning disabilities

___ poor attendance ___ poor grades ___ gang influence

___ incomplete homework ___ behavior problems

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

Date 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 wounds 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 _____: _____: _____: _____: _____: _____: _____ **CAN'T** sit still and listen for long periods of time

1 2 3 4 5 6 7

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

ENJOYS ROUTINE; easily upset when day doesn't go as usual _____: _____: _____: _____: _____: _____: _____ **ENJOYS DOING THINGS DIFFERENTLY;** may not notice small changes in

1 2 3 4 5 6 7

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 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 senses ____: ____: ____: ____: ____: ____: ____ Has strong reaction to noise, lights, hugging his/her or touching
1 2 3 4 5 6 7

Choose which sensitivity(ies) apply (choose any or all)

____ noise ____ lights ____ hugging ____ touching ____ texture(s) ____ smell(s) ___ hearing ___ other

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

Sympathetic to others; 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 ____: ____: ____: ____: ____: ____: ____ **Will easily meet** and accept new people and activities
1 2 3 4 5 6 7

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

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

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)? **(circle 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: _____