Life's Light and Hope, PLLC Sara E. Collins, LMSW
Phone: (734)582-4294
Text: (734) 265-0554
Fax: (734) 468-0106

CHILD ASSESSMENT AND PERSONAL HISTORY

Client Name: _____ DOB: _____ Age: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email Address: _____

CULTURAL/ETHNIC/RACIAL BACKGROUND (optional)

Does your child belong or identify with a cultural, ethnic, or racial group? Please describe: _____
_____
_____

SPIRITUAL/RELIGIOUS BACKGROUND

Religious Preference: _____
Does your child currently participate in religious activities? (Please explain) _____
_____

How were you referred to us? _____
Reason for seeking treatment: _____
_____
_____

Has your child received counseling services previously (outpatient - when, where): _____
_____
_____
_____
_____

Why did you stop taking your child to therapy? _____
_____

How does your child feel about being here? _____
_____

What do you believe that your child will gain from counseling? _____
_____
_____

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Please check any of the following that describe your child's **recent mood**:

( ) sad	( ) anxious	( ) depressed	( ) frightened
( ) guilty	( ) angry	( ) ashamed	( ) aggressive
( ) resentful	( ) worthless	( ) tearful	( ) irritable
( ) confused	( ) confused	( ) jealous	( ) jealous'
( ) hopeless	( ) extreme ups/ downs	( ) change in eating habits	( ) change in sleeping habits

( ) Other_____
( ) Other _____

Please check any of the following that describe your child's **typical behavior**:

( ) Does not feel liked
( ) Isolated
( ) Shy with children
( ) Shy with adults
( ) Prefers to be alone
( ) Worries
( ) Moody
( ) Sad
( ) Cries easily
( ) Expects failure
( ) Does not share
( ) Lacks motivation
( ) Preoccupied with sexual thoughts
( ) Compulsive behavior
( ) Talks impulsively
( ) Feelings of guilt
( ) Easy to anger

( ) Stubborn
( ) Defiant
( ) Bed-wetting present
( ) Bed-wetting past
( ) Soiling
( ) Unusual thinking
( ) Unusual behavior
( ) Violent behavior
( ) Destruction of property
( ) Not always truthful
( ) Fails to understand consequences
( ) Sexual acting out
( ) Tics or twitches
( ) Ritualistic behavior
( ) Acts impulsively
( ) Does not like self

Aggressive with:
( ) Peers
( ) Siblings
( ) Adults
( ) Needs the last word
( ) Stealing from home
( ) Stealing from peers
( ) Will not admit to blame
( ) Sets fires
( ) Poorly organized
( ) Clumsy
( ) Takes unnecessary risks
( ) Short attention span
( ) Day dreams
( ) Jealousness
( ) Overactive
( ) Poor hygiene
( ) Sleep walking……

Describe any behaviors your child has demonstrated that cause concern: _____
_____
When was the onset of your child's symptoms? _____
_____

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What is the frequency, duration, and intensity of the symptoms experienced by your child? _____
_____

Psychiatric History

Has your child been hospitalized for psychiatric of physical health reasons? _____
_____
What was the reason? _____
Where was your child hospitalized? _____
How long was your child hospitalized? _____

Has anyone in your child's family been diagnosed with or treated for:

	Mother	Father	Aunt/Uncle	Grandparent
Bipolar Disorder	( )	( )	( )	( )
Schizophrenia	( )	( )	( )	( )
Depression	( )	( )	( )	( )
Post-Traumatic Stress Disorder	( )	( )	( )	( )
Anxiety	( )	( )	( )	( )
Alcohol Abuse	( )	( )	( )	( )
Anger	( )	( )	( )	( )
Other substance abuse	( )	( )	( )	( )
Suicide	( )	( )	( )	( )
Other: _____	( )	( )	( )	( )

Has your child had problems with alcohol or drugs at any time (please list drugs of choice and dates):
_____
_____

TRAUMA HISTORY

Has your child experienced a trauma (Sexual/ Physical/ Emotional Abuse…) _____
_____
When was this trauma experienced: _____
Who perpetrated this trauma? _____
_____

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SUICIDE RISK ASSESSMENT:

Has your child considered suicide in connection with his/her **current** concern? ( ) Yes ( ) No
Has your child **attempted suicide recently** or in the **past**? ( ) Yes ( ) No

If so, please give a brief description with dates: _____
_____

Has your child tried to hurt others or animals recently in the past? ( ) Yes ( ) No
If yes, please explain: _____
_____

FAMILY/SOCIAL SUPPORTS

Mother's name: _____
Describe your child's relationship with their mother? _____
_____

Father's name: _____
Describe your child's relationship with their father? _____
_____

Does your child have siblings (please list names and ages): _____
_____
If so, please describe your child's relationship with their siblings: _____
_____

Please list all people currently living in the home: _____
_____
Other family member(s):_____
Describe your child's relationship with this person? _____
_____

Please describe activities in which your child participates: _____
_____

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Who is in your child's social support network? (please list friends, family members, social groups…)
_____
_____

Has your child ever been involved with the police or the courts? Please explain: _____
_____
_____

MEDICAL CONDITIONS:

Does your child have any medical conditions? If so, what conditions? _____
_____

CURRENT MEDICATIONS:

Please list any medications or over the counter supplements that your child is currently taking:
_____
_____
_____
_____

Client/ Guardian Signature Date

Client/ Guardian Signature Date

Clinician Signature Date

Client Name: _____
DOB: _____