SANTA ROSA COUNSELING CENTER

CHILD/ADOLESCENT PSYCHOSOCIAL ASSESSMENT

The following necessary information will help make your first session most productive. Signed consent is required from the parent(s) or legal guardian before treatment can be provided. If you are court-mandated to receive counseling, please be prepared to provide the court order or case plan. Please bring all documents to the first session. Please **PRINT** and fill out this form **COMPLETELY**.

Date of assessment: _____

DEMOGRAPHICS

Who is providing information for this assessment?

☐ Child/Adolescent ☐ Parent/Guardian/Representative _____ Name _____ Relationship

Last Name First Middle

Date of Birth Age Parent/Guardian Names

Street Address City State Zip Code

Telephone (Cell) (Home) (Work) Parent Email

Gender:

☐ Male ☐ Female

PERSONAL HISTORY

Why are you seeking treatment at this time and what do you hope to gain from counseling?

_____

_____

Have you had any of the problematic experiences of the following within the past 90 days? (Check all that apply)

☐ Anxiety / Panic	☐ Suicidal thoughts	☐ Family / Parent conflict
☐ PTSD / Trauma	☐ Suicide attempts	☐ Academic Problems
☐ Obsessive / Intrusive thoughts	☐ Self injury	☐ Legal/Juvenile Justice
☐ Depression	☐ Thoughts of harming others	☐ Physical / Medical problems
☐ Concentration / Focus	☐ Abuse / Violence	☐ Hospitalization
☐ Hyperactivity / Impulsivity	☐ Grief / Death	☐ Fire setting
☐ Anger management	☐ Addiction / Dependency	☐ Cruelty to animals
☐ Behavior	☐ Developmental delay	☐ Other _____

PSYCHIATRIC HISTORY

Starting with most current, please list current and past mental / behavioral health medications:

Medication	Dosage	Reason	Doctor / ARNP	Still taking?

Have you ever been in counseling before? ☐ Yes ☐ No

Have you ever been admitted into a hospital for mental / behavioral health? ☐ Yes ☐ No

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

CLINICAL NOTES

Santa Rosa Counseling Center
5642 Jones Street, Milton, Florida 32570
Office (850) 626-7779 Fax (850) 626-7171
santarosacounselingcenter.com

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MEDICAL

Who is your primary care physician? _____ ☐ Do not have

List any medical symptoms and medications: _____

Describe your sleep patterns: _____

VOCATIONAL / EDUCATIONAL

_____ ☐ Regular ☐ ESE ☐ Gifted

School Grade

Please indicate any aggravating behaviors or circumstances: (Check all that apply)

☐ Poor performance	☐ Repeated grade	☐ Suspended
☐ Disruptive / Defiant	☐ Excessive absences	☐ Dropped out
☐ Social problems	☐ Tardy / Skipping class	☐ Expelled / Dismissed

LEGAL HISTORY

Have you been arrested in the past two years?	☐ Yes	☐ No
Are you involved with a DCF/FFN case or investigation?	☐ Yes	☐ No
Are you court ordered for services?	☐ Yes	☐ No

SUBSTANCE USE

Describe your history of substance use below, even casual or recreational experiences: ☐ Family history

_____

FAMILY HISTORY

Describe your relationship with who you are **raised by** growing up until now:

_____

Describe your relationship with your **siblings** growing up until now: (with names and ages) ☐ Not applicable

_____

Describe your home environment: _____

SOCIAL / SUPPORT SYSTEM

Who do you talk to for support and guidance? _____

Who are your close friends? _____

What are your interests and what do you do for fun? _____

Do you attend church or participate in other religious activities? ☐ Yes ☐ No

If you could change one thing about your family or yourself, what would it be?

_____

_____

Patient Name Parent/Guardian Name Parent/Guardian Signature

PROVIDER SIGNATURE

_____

☐ K. ALESIA WILLIS, LMFT, LMHC	☐ SUE GESSLER, LMHC	☐ BRANDY INGRAM, LCSW
☐ BRIAN E. WILLIS, LMHC	☐ BRITTANY PAQUETTE, LMHC	☐ ROBERT FILLINGIM, LMHC
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STAFF NOTES