

**PSYCHOSOCIAL ASSESSMENT INFORMATION**

Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_ Sex %M %F

Person Completing Form \_\_\_\_\_ Relationship to Client \_\_\_\_\_

**PRESENTING PROBLEM**

Briefly describe issue/problems which led to your decision to seek services: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How severe do you rate the presenting problem on a scale of 1 – 10 with 10 being the most severe? (please circle one)

1      2      3      4      5      6      7      8      9      10

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

One Week      One Month      1 – 6 Months      6 Months – 1 Year      Longer Than One Year

In what setting does this problem cause distress? (circle all that apply)

Home      School      Work      Community

How do you rate your child's ability to cope with problem on a scale of 1 – 10 with 1 being the least able to cope? (please circle one)

1      2      3      4      5      6      7      8      9      10

Do you have concerns about the following areas? (check all apply)

- Change in sleep patterns       Change in appetite       Hygiene/Grooming       Activities/play
- Concentration/Academics       Social Relationships       Mood       Behavior

If so, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

How would you describe your child's overall health? \_\_\_\_\_

Does your child have any health concerns?  Yes  No If yes, please describe \_\_\_\_\_

Does your child have any recurrent medical conditions such as ear infections, asthma or allergies?  Yes  No If yes, please describe \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ Phone No. \_\_\_\_\_  None  Unknown

Does your child take any medications?  Yes  No If yes, please list including psychotropic, over-the-counter & herbal meds

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

Is your child taking the medications as prescribed?  Yes  No If No, please explain \_\_\_\_\_

Has your child ever had any serious accidents/illnesses or hospitalizations  Yes  No If yes, please describe below:

## 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 illness, emotional or psychological condition?  Yes  No If yes,

What was the diagnosis? \_\_\_\_\_ When? \_\_\_\_\_ By Whom? \_\_\_\_\_

Has your child received counseling services, received emergency room care or been hospitalized for mental illness or drug/alcohol concerns in the past  Yes  No If yes, please provide dates of service and reason for treatment \_\_\_\_\_

### FAMILY HISTORY

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Lives with child                      Currently Employed                      Occupation: \_\_\_\_\_  
 Does not live with child                       Yes  No                      Employer: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Lives with child                      Currently Employed                      Occupation: \_\_\_\_\_  
 Does not live with child                       Yes  No                      Employer: \_\_\_\_\_

Are there custody and/or visitation orders are in place?  Yes  No If yes, **a copy will be needed for the client's record.**

List names, gender, ages and relationships of immediate family members. Please include all members currently living in household.

Name	Gender	Age	Relationship (biological, step, half, etc.)	Lives with child
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does your child consider anyone else to be a "parent" in his/her life?  Yes  No If yes, whom? \_\_\_\_\_

Describe your relationship with your child: \_\_\_\_\_

What do you find most challenging in parenting your child? \_\_\_\_\_

What kind of discipline works best with your child? \_\_\_\_\_

Describe your child's relationship with siblings: \_\_\_\_\_

Describe any recent changes in the family system (i.e., change in home location, major events or illness, significant losses, etc.)

Family Concerns: (check if appropriate)

_____ Marital Difficulties	_____ Death in Family	_____ Aging Grandparents	_____ Job Loss
_____ Drug Addiction	_____ Alcoholism	_____ Financial Problems	_____ Single Parent
_____ Serious Illnesses	_____ Birth of New Child	_____ Other please specify _____	

Please check to identify if any family members have a history of any of the following:

	Relationship to child		Relationship to child
_____ Depression	_____	_____ Trauma History	_____
_____ Anxiety	_____	_____ Domestic Violence Victim	_____
_____ Bipolar DO	_____	_____ Alcohol Use/Abuse	_____
_____ Schizophrenia	_____	_____ Drug Use/Abuse	_____
_____ ADHD/ADD	_____	_____ Incarceration	_____

### SCHOOL HISTORY

Is your child currently enrolled in school?  Yes  No If no, what was the last year of school the child completed? \_\_\_\_\_

Name of Current School: \_\_\_\_\_ Home-schooled  Yes  No Grade: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Contact Information: \_\_\_\_\_

How would you describe your child's achievement/grades in school? \_\_\_\_\_

How would you describe your child's attitude towards school/education? \_\_\_\_\_

Has your child ever been a victim of bullying?  Yes  No If yes, describe: \_\_\_\_\_

Are there any 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: \_\_\_\_\_

### HOUSING

Do 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)

Homeless  Emergency Shelter  Child and family live with relatives/friends (permanent)

How long has this child lived in the current living situation? \_\_\_\_\_

How many times has the child moved in the past two years? \_\_\_\_\_

### OUT OF HOME PLACEMENT

Has your child ever been in state custody?  Yes  No If yes, please describe: \_\_\_\_\_

History of state involvement  None  Past  Current, please describe: \_\_\_\_\_

### CULTURAL/SPIRITUAL PREFERENCES

Does your child have any cultural or spiritual preferences?  Yes  No If yes, describe \_\_\_\_\_

Does your family have any cultural or spiritual preferences?  Yes  No If yes, describe \_\_\_\_\_

### SOCIAL AND BEHAVIOR CHECKLIST

Please check any of the following that describe behavior shown by your child:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> more interested in things than in people | <input type="checkbox"/> frequent tantrums   | <input type="checkbox"/> frequent nightmares      |
| <input type="checkbox"/> rocks back and forth                     | <input type="checkbox"/> bangs head          | <input type="checkbox"/> holds breath             |
| <input type="checkbox"/> has poor bowel control (soils self)      | <input type="checkbox"/> wets bed            | <input type="checkbox"/> sucks thumb              |
| <input type="checkbox"/> does not get along with siblings         | <input type="checkbox"/> prefers to be alone | <input type="checkbox"/> shows daredevil behavior |
| <input type="checkbox"/> has special fears, habits etc....        | <input type="checkbox"/> gives up easily     | <input type="checkbox"/> bites nails              |
| <input type="checkbox"/> online dating                            | <input type="checkbox"/> skipping school     | <input type="checkbox"/> gang involvement         |
| <input type="checkbox"/> unprotected sex                          | <input type="checkbox"/> cutting             | <input type="checkbox"/> stealing                 |
| <input type="checkbox"/> running away                             | <input type="checkbox"/> bullying others     | <input type="checkbox"/> setting fires            |
| <input type="checkbox"/> dangerous dieting                        |  |   |

### ALCOHOL/DRUG ASSESSMENT

Does your child use tobacco or smokeless tobacco?  Yes  No  Do not know – If yes describe: \_\_\_\_\_

Does your child use alcohol or drugs?  Yes  No  Do not know – If yes describe: \_\_\_\_\_

Has your child ever used medications (prescription drugs or over the counter medication) for recreational purposes?

Yes  No  Do not know – If yes describe: \_\_\_\_\_

### RISK ASSESSMENT

Please check any of the following that describe how you believe your child has been feeling lately:

- |                                  |                                    |                                    |                                     |                                    |                                   |  |
|----------------------------------|------------------------------------|------------------------------------|-------------------------------------|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> sad     | <input type="checkbox"/> anxious   | <input type="checkbox"/> depressed | <input type="checkbox"/> frightened | <input type="checkbox"/> guilty    | <input type="checkbox"/> angry    | <input type="checkbox"/> aggressive        |
| <input type="checkbox"/> ashamed | <input type="checkbox"/> resentful | <input type="checkbox"/> worthless | <input type="checkbox"/> tearful    | <input type="checkbox"/> irritable | <input type="checkbox"/> confused | <input type="checkbox"/> extreme ups/downs |
| <input type="checkbox"/> jealous | <input type="checkbox"/> hopeless  | <input type="checkbox"/> helpless  | <input type="checkbox"/> frustrated | <input type="checkbox"/> worried   | <input type="checkbox"/> shy      | <input type="checkbox"/> impulsive         |

Has your child ever considered suicide in connection with his/her **current** problem?  Yes  No  Do not know

If yes, please give a brief description with dates: \_\_\_\_\_

Has your child ever **considered suicide** in the **past**?  Yes  No  Do not know

Has your child **attempted suicide recently** or in the **past**?  Yes  No  Do not know

If yes, please give a brief description with dates: \_\_\_\_\_

Has your child had any **homicidal thoughts recently** related to current problem?  Yes  No  Do not know

If yes, please give a brief description with dates: \_\_\_\_\_

Has your child ever **considered homicide** in the **past**?  Yes  No  Do not know

If yes, please explain: \_\_\_\_\_

**STRENGTHS/RESOURCES**

What limitations/barriers does your child/family have? \_\_\_\_\_

\_\_\_\_\_

What strengths does your child/family have? \_\_\_\_\_

\_\_\_\_\_

What resources does your child/family have to help with your current problem/concerns? \_\_\_\_\_

\_\_\_\_\_

Who does your child count on for support? \_\_\_\_\_

\_\_\_\_\_

**CURRENT NEEDS/GOALS**

What do you feel is your child's biggest need right now? \_\_\_\_\_

\_\_\_\_\_

What do you most hope your child will gain from coming to counseling? \_\_\_\_\_

\_\_\_\_\_

If you could pick three (3) goals for your child to work on in counseling, what would they be?

Goal 1: \_\_\_\_\_

Goal 2: \_\_\_\_\_

Goal 3: \_\_\_\_\_

**Is there any additional information you would like for me to know?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Printed name of person completing this form**

\_\_\_\_\_  
**Relationship to the child**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**