BRIGHTER FUTURES NOW,LLC

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PSYCHOSOCIAL ASSESSMENT INFORMATION-CHILD

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
_____	____	____	_____	☐Yes ☐No
_____	____	____	_____	☐Yes ☐No
_____	____	____	_____	☐Yes ☐No
_____	____	____	_____	☐Yes ☐No
_____	____	____	_____	☐Yes ☐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:

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

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:

____ sad ____ anxious ____ depressed ____frightened ____guilty ____angry ____aggressive
____ ashamed ____ resentful ____ worthless ____tearful ____irritable ____confused ____ extreme ups/downs
____ jealous ____ hopeless ____ helpless ____ frustrated ____ worried ____ shy ____ 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**