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COUNSELING CHILD ASSESSMENT
REFERRAL AND BACKGROUND INFORMATION
(Child and Adolescent Form)

Today's Date:
Child's Full Name: ______________________
Date of Birth:____________________
Age:_____________
Home address (es):_________________________________

Medical Insurance/ ID #:_________________________

Parents'/guardians' names:
____
cell telephones/fax #s/e-mail addresses:
(Mom):____
(Dad): ____

Names, ages, and birth dates of siblings and other household members (including pets) :
____
____

Parents' occupations and educational backgrounds:
Mom:____
Dad:____
Other:
____
Child's height and weight (numbers and/or percentiles if available):____
____
____
Current Primary Care Physician or Practice:
____

Date of last physical: ________________

DEVELOPMENTAL HISTORY:

☐ Developmental History Unknown

Were there any medical problems during pregnancy? ☐ Yes ☐ No

If so, please describe: Was your child born on time? ☐ Yes ☐ No

If not, at how many weeks gestation? ________________________

Child's birth weight: _______________________ (lbs, oz)

Was your child born: ☐ Naturally ☐ via C-section

Were there any medical problems during labor or delivery? ☐ Yes ☐ No

If so, please describe:

____
____
____

Any difficulties post-delivery (post partum depression, Neonatal ICU?) ☐ Yes ☐ No

If so,
describe:____
____

Was your child exposed to medications, toxins, alcohol or cigarettes before birth? ☐ Yes ☐ No

If so, please list:

____
____

Were there any problems in the first year of life? ☐ Yes ☐ No

If so, please describe:

____
____

Developmental milestones:

Walking : ☐ early ☐ on time ☐ delayed Please describe:_________________________________

Talking: ☐ early ☐ on time ☐ delayed Please describe:_________________________________

Toilet Training achieved: ☐ early ☐ on time ☐ delayed

Please describe:____

Were there any difficulties meeting these milestones?

____
____
____

What is/ was your child was like during from 0-4 years of life with respect to the following attributes: Ability to soothe him/her self when upset (nap or bedtime,

playtime):____

____

Showing initiative and curiosity:

____

____

Seemed to be dependent on external rewards to achieve behaviors desired by parents:

____

____

Activity level:

____

____

What are the rewards when your child is behaving well/ properly?

____

____

____

Who is charge of discipline at home?____

Do caregivers agree on discipline? ☐ Yes ☐ No

What types of discipline methods are used?

____

____

____

Please explain any current familial stressors:

____

____

____

Please describe your child's temperament and general personality:

____

____

____

What types of activities does your child most enjoy, and does he or she participate in any structured or formal extracurricular activities?

____

____

____

What do you consider to be among your child's greatest strengths?

____
____
____

1. Briefly describe the main question, concern, and/or problem for which you are seeking evaluation at this time:

____
____
____

2. When did you first have this question, concern, or problem?

____
____
____

3. Have you ever sought assistance for this question, concern, or problem from other professionals? If so, please indicate from whom.

____
____
____

4. What is your current thinking regarding the most likely influences or causes of the concern or problem in question?

____
____
____

5. Whose idea was it to have this evaluation?

____
____
____

6. What have you said to your child about this evaluation?

____
____
____

7. What are your treatment goals?

A).____

B).____

C).____

1. Child's grade in school: _______

2. School name, address, and phone number (if handy):

____
____
____

3. Please list the names of your child's teacher (s):

____
____

4. Please list child's previous schools attended, if any, including preschool (s):

____
____
____

5. Has your child ever repeated or skipped a grade?

____
____
____

6. Has your child ever received special educational services or accommodations in school (i.e., has an IEP or 504 Plan ever been developed?).

____
____
____

7. Please describe your child's present educational program (include number of teachers, size of classrooms, description of time outside of regular classroom, extracurricular activities, etc.).

____
____
____

8. How does your child generally function in school academically and behaviorally? Please describe strengths and weaknesses and include copies of any relevant academic records (e.g., recent report cards, EOG reports, results from group standardized testing).

____
____
____

9. Has your child ever worked with a tutor outside of school?

____
____
____

10. Is there a particular person in your child's school who would be useful to contact regarding his/her functioning or the results/recommendations from this evaluation? If so, please provide the person's name and phone number if known.

____
____
____

3. Please describe any significant health problems your child has had in the past.

____
____
____

4. Does your child have any health problems at present?

____
____
____

5. Does your child take any prescribed medications, herbs, or homeopathic treatments? Please list dosages if known.

____
____
____

6. Describe your child's sleep habits/ bedtime rituals. Are there any concerns?

____
____
____

7. Describe your child's eating habits. Are there any concerns?

____
____
____

8. Does your child have any visual issues? Does s/he wear corrective lenses?

____
____
____

9. Has your child ever been suspected of having hearing problems? Any major ear infections?

____
____
____

10. Is there any family history of problems or differences with respect to learning or attention?
____
____
____

11. Is there any family history of clinically significant developmental disabilities, depression, anxiety, behavior and interpersonal problems, motor tics, and/or substance abuse?
____
____
____

Prior Evaluations, Testing, and Treatment:

1. Has your child had any previous individual psychological, psychoeducational evaluations or "testing?" If so, please describe, and provide copies of reports if possible.
____
____
____

2. How does you child tend to "test" on end-of-grade, end-of-course, or other group standardized tests (e.g., ERBs, CATs)?
____
____
____

3. Has your child ever been seen by a speech and language pathologist, occupational therapist, or a physical therapist?
____
____
____

4. Has your child ever been evaluated by or received treatment from a mental health professional?
____
____
____

Does your child have a history of

☐ Academic/ Learning Problems: ☐ Reading ☐ Math ☐ Writing ☐ School Refusal ☐ Bedwetting/ Soiling Problems: ☐ Yes ☐ No

☐ Abuse History: ☐ Physical ☐ Sexual ☐ Verbal ☐ Neglect ☐ Witnessing Domestic Violence/ Abuse? ☐ Yes ☐ No

☐ Experiencing the loss of death of a close loved one? ☐ Yes ☐ No If yes, please list (who and date):

☐ Experiencing any other traumatic events (i.e., bullying, medical, natural events, school/ community violence)? ☐ Yes ☐ No If yes, please list (what and date):

☐ Hearing voices no one else hears or seeing things no one else sees? ☐ Yes ☐ No ☐

History of Harm to Self/ Others:
____
____
____

Past Suicidal Thoughts/ Gestures: ☐ Denied ☐ Ideation ☐ Plan ☐ Intent Current Suicidal Thoughts/ Gestures: ☐ Denied ☐ Ideation ☐ Plan ☐ Intent

Aggression towards other siblings/ peers: ☐ Yes ☐ No If yes, please describe:____
____
____

Past Homicidal Thoughts/ Gestures: ☐ Denied ☐ Ideation ☐ Plan ☐ Intent

Current Homicidal Thoughts/ Gestures: ☐ Denied ☐ Ideation ☐ Plan ☐ Intent

Past history of self-harm: ☐ Yes ☐ No

Currently engaging in self-harm: ☐ Yes ☐ No
If yes, age of onset, duration, and was medical attention needed:____
____

CURRENT CONCERNS:
Emotional:

☐ Irritable or Depressed Mood ☐ Avoids certain items, places, situations, persons ☐ Tearfulness or Frequent Crying Spells ☐ Panic Attacks ☐ Loss of Interest in Activities ☐ Low Self-Esteem ☐ Sadness ☐ Loss of Energy ☐ Repetitive/ Obsessive Thoughts ☐ Confusion About Self ☐ Mood Swings ☐ Anxiety/ Worry/ Fears ☐ Easily Startled ☐ Temper Tantrums ☐ Flashbacks ☐ Loss of Energy ☐ Trouble Expressing Emotions ☐ Nightmares ☐ Trouble Calming Down ☐ Overreacts When Faced with a Problem ☐ Hides Feelings ☐ Other (list):

Physical:

☐ Difficulty/ Changes in Sleep ☐ Changes in Appetite or Eating Habits ☐ Headaches ☐ Dizziness ☐ Change in weight ☐ Stomachaches ☐ Other (list):

Behavioral: ☐ Concentration/ Focus Problems ☐ Avoids Tasks that Are Difficult or Boring ☐ Loses Items ☐ Doesn't Complete Tasks to Completion ☐ Trouble Remaining Seated ☐ Easily Distracted ☐ Daydreams/ Zones Out ☐ Always "On the Go" ☐ Restless or Fidgety ☐ Impulsive ☐ Hyper-focuses ☐ Makes Careless Mistakes ☐ Self-Hygiene Habits ☐ Strict Routines ☐ Limited/ Specific Interests ☐ Trouble with Transitions ☐ Repetitive Body Movements ☐ Verbal Aggression ☐ Physical Aggression ☐ Lying ☐ Stealing ☐ Cruelty to Animals ☐ Defiance/ Noncompliance ☐ Tantrums ☐ Truancy (home or school) ☐ Sexual Behaviors ☐ Blames Others ☐ Argues with Adults ☐ Trouble Accepting Responsibility/ No ☐ Fire-setting ☐ Substance Use ☐ Legal Problems ☐ Hair-picking ☐ Purging/ Restricting Food ☐ Calorie Counting ☐ Excessive Exercise ☐ Other (list):

Social:
☐Family Conflicts ☐ Negative Peer Relationships ☐ Isolates Self / Withdraws from Others ☐ Communication/ Respect with Adults ☐ Making Friends ☐ Keeping Friends ☐ Poor Eye Contact ☐ Reading Social Cues ☐ Conversations ☐ Respecting Personal Space ☐ Sportsmanship ☐ Sharing ☐ Clingy/ Trouble Separating ☐ Attachment to Others ☐ Joining In ☐ Social Media/ Online Interactions ☐ Bullies Others ☐ History of Being Bullied ☐ Overly Stimulated

History of speech therapy? ☐ Yes ☐ No If so, when/ where?

____

History of occupational therapy? ☐ Yes ☐ No
If so, when/ where?

____

Does your child exhibit any sensory difficulties? ☐ Yes ☐ No If so, please describe (loud sounds, textures, smells, crowds, lights, etc.):

MEDICAL HISTORY

How is your child's general health? History of: ☐ Physical Disabilities ☐ Asthma ☐ Head Injury ☐ Surgeries ☐ Stitches ☐ Broken Bones ☐ Burns ☐ Overnight Hospitalizations ☐ Frequent Ear Infections ☐ Seizures ☐ Vision Problems ☐ Loss of Consciousness ☐ Chronic Illness ☐ Severe Illness ☐ Hearing Difficulties ☐ Constipation/ GI Problems ☐ Feeding or Eating Issues ☐ Allergies (List): Previous medication trials? ☐ Yes ☐ No Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled.

You may skip this section if you bring a printout of meds generated by your pharmacy at the time of the initial appointment

Current medication? ☐ Yes ☐ No
Please list any medication(s) and the dosage(s) your child is currently taking, including any over-the-counter medications (daily vitamins, hormones, herbal supplements, allergy medications and/or frequent dosages of acetaminophens/ ibuprofen):
____
____
____

(You may skip this section if you bring a printout of meds generated by your pharmacy)

ACADEMIC HISTORY Please list all schools attended and for which ages/ grades.

Preschool/ Daycare:
Elementary: ___________________________________
Middle School: _________________________________
High School: ___________________________________
Current School: _________________________________
Current Grade: _________
Type of School: ☐ Public ☐ Private ☐ Charter ☐ Homeschool
Current Grades: _____________
Recent change in grades? ☐ Yes ☐ No Skipped or Repeated Grade(s)? ☐ Yes ☐ No
If yes, please explain: ____
Has your child ever had an IEP (Individualized Education Plan)? ☐ Yes ☐ No
If so, starting in which grade? ____
In which category: ☐ OHI ☐ BED ☐ AU
Has your child ever had a 504 Plan ☐ Yes ☐ No
If so, starting in which grade?____
Has your child had educational testing to identify a learning problem or giftedness?
☐ Yes ☐ No

*If so, please provide copies of any reports/ evaluation at your appointment.

Are you concerned about your child's academic performance? ☐ Yes ☐ No

If so, please explain:
____
____
____

Please list any other notable school problems (i.e., attention, focus, avoidance/ school refusal, behavior, etc.):
____
____
____

FAMILY HISTORY

Child is: ☐ Biological ☐ Adopted ☐Foster ☐ Other ___________________________________

Biological Parents are: ☐ Married ☐Divorced* ☐ Separated* ☐ Never Married ☐ Other Type of Legal Custody: ☐ Sole* ☐ Joint☐ Other ________________________________ Type of Physical Custody: ☐ Sole ☐ Joint☐ Other ________________________________

* Please provide current separation agreement or court order to verify legal custody

Do you currently have any pending custody matters? ☐ Yes ☐ No

Has Child Protective Services ever been involved or has there been an abuse report filed against any of the child's care takers? ☐ Yes ☐ No

If yes, please explain (When, what, who was involved, what state, what was the finding):
____
____
____

Who does the child currently live with?:
____
____
____

How do family members get along?
____
____
____

Marital/ Couple's Relationship: ☐ Positive ☐ Negative ☐ Variable ☐ N/A
Co-parent's Relationship: ☐ Positive ☐ Negative ☐ Variable ☐ N/A
Mother with Child: ☐ Positive ☐ Negative ☐ Variable ☐ N/A
Father with Child: ☐ Positive ☐ Negative ☐ Variable ☐ N/A
Client & Sibling Relationship: ☐ Positive ☐ Negative ☐ Variable ☐ N/A
Extended Family Relationships: ☐ Positive ☐ Negative ☐ Variable ☐ N/A

MENTAL HEALTH HISTORY Previous diagnosis(es)? ☐ Yes ☐ No
If yes, specify:

____
____
____

Previous history of therapy/ counseling? ☐ Yes ☐ No

If yes, specify name of therapist/agency, dates of treatment, type of therapy if you know it (CBT, DBT, etc.):

____
____
____

Previous history of psychological evaluation? ☐ Yes ☐ No If yes, specify date(s) and evaluator or agency. Please provide copies of any reports or evaluations if you have them.

Previous history of psychiatric hospitalizations? ☐ Yes ☐ No

If yes, specify hospital name, dates, and length of stay:

____
____
____

Previous psychiatric hospitalizations for family members? ☐ Yes ☐ No

If yes, please specify:

____
____
____

Any family members with history of mental health disorders? ☐ Yes ☐ No

If yes, specify:

____
____
____

Any family members with history of suicide? ☐ Yes ☐ No

If yes, specify:

____
____
____

SOCIAL INTERACTIONS/ FRIENDSHIPS/ RECREATION

Does your child relate/ play well with others: ☐ Yes ☐ No

If no, describe:

Your child gets along better with peers who are (check all that apply):
☐ Younger ☐ Same Age ☐Older ☐Adults ☐ No preference

What activities or hobbies does your child enjoy?

____
____
____

CULTURAL BELIEFS AND PRACTICES

Does your family identify with a specific cultural or ethnic group? ☐ Yes ☐ No If yes, specify:

____
____
____

Does your family belong to a particular religion or spiritual group? ☐ Yes ☐ No

If yes, specify:

____
____
____

If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is important to you? ☐ Yes ☐ No

If yes, specify:

____
____
____

If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is important to you? ☐ Yes ☐ No

If yes, specify:

____
____
____

Are there any other cultural/religious considerations/ needs that we should be aware of?
☐ Yes ☐ No

If yes, specify:

____
____
____

What are your child's strengths?

____
____
____

Please share any other information that you believe may help my ability to provide effective care for your child.

____
____
____