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ASSESSMENT AND HISTORY INFORMATION-CHILD/ADOLESCENT

Client's Name:_________________________________DATE:______________

Has the client ever been treated by a psychiatrist? ____YES____NO

If "YES" name/agency of psychiatrist and dates of treatment:

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Has the client ever been treated by a counselor/therapist?____YES____NO

If "YES" name/agency of counselor/therapist and dates of treatment:

____

Client's Physician:____

Current medication:____

Has client been diagnosed with developmental problems?____YES____NO

Does client have any speech impairment problems?____YES____NO

Has client been exposed to trauma?____YES____NO

Any mental health problems on fathers/mothers side of family?____YES____NO

If "YES", please indicate who and what diagnosis:

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Any complications during pregnancy?____YES____NO

Any complications at birth?____YES____NO

Briefly describe reasons for seeking counseling services:

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Briefly describe what has been tried to improve the situation:

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Please place a number that best corresponds to the issue listed below:

NOT APPLICABLE NOT VERY SERIOUS SERIOUS VERY SERIOUS

1 2 3 4 5 6 7 8

___Abuse-physical ___Abuse-sexual ___Abuse-emotional

___Abuse-neglect ___Aggression-violence ___Anger, hostility, irritability

___Anxiety, nervousness ___Attention, distraction ___Confusion

___Compulsions ___Cruelty to animals ___Crying, sadness

___Indecision ___Delusions (false ideas)___Depression

___Divorce, seperation ___Eating problems ___Grieving

___Guilt ___Headaches ___Impulsiveness

___Loss of Control ___Unmotivated ___Memory problems

___Mood swings ___Obsession/compulsion___Panic/Anxiety attacks

___School problems ___Low self-esteem ___Sleep problems

___High stress ___Suicidal thoughts ___Temper problems

OTHER:____

Please rate below on a scale of 1 through 10, 1=not at all and 10=very much

___Client is close and has good relationship with siblings

___Client is close and has good relationship with dad

___Client is close and has good relationship with mom

___Client has several close friends

___Client often has nightmares

___Client prefers to send time alone

___Client does not make eye contact when spoken to

___Client does not like being around other people

___Client likes self

In the past 36 months has there been a death of a family member or someone close to the child?____YES____NO If yes, who?_______________when?___________

Prior to 36 months, has there been a death of someone close to the child?

____YES____NO if yes, who?__________________when?__________________

Any other information not included on this form that is pertinent for therapist to know:

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