Name:

SS#: _____

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CHILD/ADOLESCENT ASSESSMENT
Page 1

DATE: _____

DO YOU OR YOUR CHILD/ADOLESCENT HAVE ANY PHYSICAL IMPAIRMENTS OR LIMITATIONS WHICH MAY REQUIRE SPECIAL ACCOMMODATION, SPECIAL ARRANGEMENTS, OR MAY AFFECT YOUR ABILITY TO PARTICIPATE IN YOUR CHILD'S/ADOLESCENT'S ASSESSMENT OR TREATMENT OR THAT MAY AFFECT YOUR CHILD'S/ADOLESCENT'S TREATMENT (i.e., reading difficulties, hearing loss, vision loss, speech impairment)? ☐Yes ☐ No
If yes, please explain:

_____

****

CURRENT SITUATION

What concern brings you here: (How long has this been a problem?)
(What have you done, or are you doing, to resolve this problem?)

_____

_____

_____

_____

_____

_____

_____

What do you hope to accomplish in this session/in therapy?

_____

_____

_____

Name:

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CHILD/ADOLESCENT ASSESSMENT
Page 2

DEVELOPMENTAL HISTORY

PRENATAL/BIRTH HISTORY

Health of mother: ☐ Good ☐ Fair ☐ Poor ☐ Do not know

Did the mother use any of the following during pregnancy?

☐ Alcohol
☐ Cigarettes
☐ Coffee/Caffeine drinks
☐ Marijuana/Cocaine/Crack
☐ Prescription drugs (list): _____ _____

_____ _____

_____ _____

☐ None of the above

Any medical complications during pregnancy? ☐ Yes ☐ No
Comment: _____

Length of Pregnancy in months or weeks if known: _____

Birth Weight: _____

Were there any complications during or following birth?
(check all that apply)

☐ Baby given oxygen
☐ Baby on heart monitor
☐ Birth defects
☐ Blood transfusions (baby)
☐ Delivery aided by instrument
☐ Delivery by cesarean section
☐ Incubator
☐ Jaundice
☐ Problems breathing
☐ Problems eating/digestion
☐ Problems sucking
☐ Rashes
☐ Very active
☐ Very quiet
☐ Other _____

☐ None of the above

Number of days baby stayed in the hospital following delivery: _____

Number of days mother stayed in the hospital following delivery: _____

Comments: _____

_____

_____

Name:

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CHILD/ADOLESCENT ASSESSMENT
Page 3

DEVELOPMENTAL HISTORY (cont.)

EARLY DEVELOPMENT

Your child's/adolescent's approximate age when he/she began:

walking _____ months

talking (single words) _____ years

talking (short sentences -2 + words) _____ years

toilet training: daytime _____ years nighttime _____ years

Overall, you feel your child/adolescent developed at the following rate: ☐ Slow ☐ Normal ☐ Rapid

Comments: _____

_____

_____

During the first three years of life, your child frequently exhibited:
(check all that apply)

- ☐ Accident prone behavior
- ☐ Avoidance of cuddling
- ☐ Colic
- ☐ Destructive behavior
- ☐ Distractibility
- ☐ Extreme mood changes
- ☐ Feeding problems
- ☐ Head banging
- ☐ Lack of coordination
- ☐ Over active behavior
- ☐ Problems with sleeping/waking patterns
- ☐ Restless behavior
- ☐ Self-hurting behavior
- ☐ Temper tantrums
- ☐ Unresponsive to discipline
- ☐ Withdrawn Behavior

☐ None of the above

Comments: _____

_____

_____

Name:

SS#: _____

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CHILD/ADOLESCENT ASSESSMENT
Page 4

DEVELOPMENTAL HISTORY (cont.)

SEXUALITY

Is your child/adolescent: ☐ Prepubescent ☐ Pubescent

Menses onset: _____age

To the best of your knowledge, your child/adolescent is:

sexually active	☐ Yes	☐ No	☐ Unknown
uses contraceptives	☐ Yes	☐ No	☐ Unknown
history of pregnancy	☐ Yes	☐ No	☐ Unknown
history of abortion	☐ Yes	☐ No	☐ Unknown
fathered a child	☐ Yes	☐ No	☐ Unknown

Do you have any concerns regarding your child's/adolescent's sexual development or sexual orientation? ☐ Yes ☐ No

Comments: _____

_____

SIGNIFICANT EVENTS

☐ Change of school
☐ Death in family
☐ Divorce or separation
☐ Frightening experience for child/adolescent
☐ Loss of someone close to child/adolescent
☐ Move to a new place
☐ Serious illness or injury to family member/friend
☐ Other

☐ None of the above

Comments: _____

_____

_____

Name:

SS#: _____

Case ID#: _____

CHILD/ADOLESCENT ASSESSMENT
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HEALTH/MEDICAL HISTORY

Primary Care Physician/Pediatrician _____
Height _____ Weight _____
Does your child/adolescent have any drug/food allergies? ☐ Yes ☐ No If yes, please specify.
_____
Are childhood immunizations up to date? ☐ Yes ☐ No ☐ Do not know

Does your child/adolescent have an eating or sleeping problem? (check all that apply)

- ☐ Dieting
- ☐ Overeats
- ☐ Picky eater
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Refuses to eat
- ☐ Vomiting
- ☐ Other _____

- ☐ Bedwetting
- ☐ Difficulty falling asleep
- ☐ Does not want to sleep alone
- ☐ Nightmares
- ☐ Sleeps too much
- ☐ Soiling
- ☐ Trouble staying asleep
- ☐ Very restless while sleeping
- ☐ Other _____

☐ None of the above

How would you describe the nutritional value and balance of your child's/adolescent's diet: ☐ Good ☐ Fair ☐ Poor

Has your child/adolescent been diagnosed and/or currently being treated for any of the following? (check all that apply)

- ☐ ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer/Leukemia
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Encephalitis
- ☐ Epilepsy
- ☐ Fever above 105°
- ☐ Hearing problems

- ☐ Heart problems
- ☐ HIV/AIDS
- ☐ Hydrocephalus
- ☐ Lead Poisoning
- ☐ Loss of consciousness
- ☐ Meningitis
- ☐ Mental Retardation
- ☐ Musculo-Skeletal Condition
- ☐ Seizures
- ☐ Vision problems
- ☐ Other _____

☐ None of the above

Comments: _____
_____
_____

Name:

SS#: _____

Case ID#: _____

CHILD/ADOLESCENT ASSESSMENT
Page 6

HEALTH/MEDICAL HISTORY (cont.)

Has your child/adolescent had any surgeries/accidents/conditions requiring hospitalization or same day surgery?
☐ Yes ☐ No
Date: _____ Conditions: _____

_____ _____

_____ _____

Is your child/adolescent taking any medication?
(prescription and over-the-counter) ☐ Yes ☐ No
List medication/purpose: _____ _____

_____ _____

_____ _____

BEHAVIORAL HEALTH HISTORY

Has your child/adolescent had prior mental health services, counseling and/or alcohol/drug treatment?

Outpatient		Inpatient	
Therapist/Program	Date	Hospital	Date

Has your child/adolescent: (check all that apply)

☐ Physically harmed another individual, pet, or small animal?
☐ Received medication in the past for emotional, learning, behavioral problems?
☐ Run away from home?
☐ Started a fire?
☐ Talked about or attempted suicide?
☐ Threatened to physically harm anyone?
☐ None of the above

Comments: _____

_____

_____

Name:

SS#: _____

Case ID#: _____

CHILD/ADOLESCENT ASSESSMENT
Page 7

BEHAVIORAL HEALTH HISTORY (cont.)

Has your child/adolescent ever experienced or witnessed:

- ☐ Domestic violence
- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Rape/sexual assault
- ☐ Sexual abuse
- ☐ Other significant trauma

☐ None of the above

Comments: _____

_____

_____

ACTIVITIES OF DAILY LIVING

Check areas of difficulty your child/adolescent displays when performing daily activities:

- ☐ Adapting to changes
- ☐ Attending to tasks
- ☐ Decision making
- ☐ Following a routine
- ☐ Goal setting
- ☐ Learning
- ☐ Performing Self Care (hygiene, grooming, bathing, etc.)
- ☐ Problem Solving
- ☐ Other

☐ None of the above

Comments: _____

_____

_____

Describe involvement in activities outside the home (hobbies, sports, volunteer activities, etc.):

_____

_____

_____

Have your child's/adolescent's leisure time activities increased/decreased over the past 6 months? ☐ Yes ☐ No

Comments: _____

_____

_____

Name:

SS#: _____

Case ID#: _____

CHILD/ADOLESCENT ASSESSMENT
Page 8

CULTURAL/ETHNIC/SPIRITUAL:

Cultural/ethnic/racial issues that need consideration: _____

Religious/spiritual issues that need consideration: _____

EDUCATION

School presently attending _____ Grade _____

School related issues: (check all that apply)

- ☐ Academic problems
- ☐ Advanced a grade
- ☐ Attendance
- ☐ Behavior
- ☐ Detention
- ☐ Held back a grade
- ☐ Homework
- ☐ Met with school counselor
- ☐ Peer relationships
- ☐ Relationship with teacher(s)
- ☐ Required special help
- ☐ Suspension/expulsion
- ☐ Tested by school psychologist (ADD, ADHD, other)
- ☐ Transportation

☐ None of the above

Comments: _____

_____

_____

FAMILY HISTORY

List all the people who are currently living in the household:

Name	Age	Relationship to child/adolescent

Name:

SS#: _____

Case ID#: _____

CHILD/ADOLESCENT ASSESSMENT
Page 9

FAMILY HISTORY (cont.)

List sibling(s) not living in the household:

Name Age Relationship to child/adolescent

_____

_____

_____

Custody Status: ____ Birth Parents ____Adopted: Age of adoption ____

____ Mother only ____Father only

____ Joint Custody ____Ward of the court

____ Other relative - Please specify _____

Frequency of contact between non-custodial parent and your child/adolescent:_____

Is your child/adolescent experiencing any problems in relationships with: (check all that apply)

- ☐ Child Care Providers
- ☐ Father
- ☐ Mother
- ☐ Siblings
- ☐ Stepfather
- ☐ Stepmother
- ☐ Step-Siblings
- ☐ Other

☐ None of the above

Comments: _____

_____

_____

Have any family members had problems with substance abuse (drugs, alcohol) or with mental/emotional problems?

☐ Yes ☐ No

Comments: _____

_____

_____

Name:

SS#: _____

Case ID#: _____

CHILD/ADOLESCENT ASSESSMENT
Page 10

FINANCIAL

Are there family financial concerns? ☐ Yes ☐ No

Comments: _____

_____

_____

Does your child/adolescent have the opportunity to earn spending money? ☐ Yes ☐ No

Comments: _____

_____

_____

ALCOHOL AND DRUG

Describe what you know about your child's/adolescent's alcohol/tobacco/drug use:

_____

_____

_____

Have others expressed concern about your child's/adolescent's alcohol/tobacco/drug use? ☐ Yes ☐ No

Comments: _____

_____

_____

Has your child/adolescent ever experienced any of the following with his/her use of alcohol, tobacco, prescription medications or other drugs? (check all that apply)

- ☐ Change in peers
- ☐ Emotional problems
- ☐ Giving up previously enjoyed activities
- ☐ Increased frequency/quantity of use
- ☐ Legal problems
- ☐ Memory lapse after use
- ☐ Mood swings
- ☐ Physical problems
- ☐ Relationship problems
- ☐ School problems
- ☐ Stealing from family/friends
- ☐ Withdrawal symptoms
- ☐ Work problems

☐ None of the above

Name:

SS#: _____

Case ID#: _____

CHILD/ADOLESCENT ASSESSMENT
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LEGAL

Has your child/adolescent ever had involvement with the legal system? ☐ Yes ☐ No

Does you child/adolescent have any current pending legal charges? ☐ Yes ☐ No

Is he/she on probation? ☐ Yes ☐ No

Has he/she ever been in detention/jail? ☐ Yes ☐ No

Does your child/adolescent have any gang involvement? ☐ Yes ☐ No

Are there any legal problems having to do with other family members? ☐ Yes ☐ No

Comments: _____

_____

_____

Thank you for providing this information.

_____ _____
Parent/Guardian Signature Completing the Form — Date

_____ _____
Clinician — Date

_____ _____
Reviewed/Updated — Date

_____ _____
Reviewed/Updated — Date

ALERT®

Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name | First Name | Child's Date of Birth: (mm/dd/yy)

Subscriber ID | Authorization #

Clinician Last Name | First Name | Today's Date: (mm/dd/yy)

Clinician ID/Tax ID | Clinician Phone | State | MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+

24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days

25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days

59243

Clinician: Please fax to (800) 985-6894

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