

CONCERN™ SERVICES
CHILD/ADOLESCENT ASSESSMENT

Name: _____
SS#/ID#: _____

CUSTODY STATUS

Please indicate who has custody of the child/adolescent.

- Birth Parents Adopted: Age of adoption ____ Mother only Father only Joint Custody
 Ward of the court Other relative, specify _____

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

INSURANCE COVERAGE: _____

CURRENT SITUATION

Why have you brought your child/adolescent for counseling? How long has this been a

problem? What have you done, or are you doing, to resolve the problem(s)? What do you hope to accomplish in this session/with counseling? _____

HEALTH AND WELLNESS HISTORY

Primary Care Physician/Pediatrician: _____

Date last seen by Physician: _____ Date of last physical: _____ Height _____ Weight _____

Please describe your child's leisure activities: _____

Does your child exercise? Yes No If yes, how many times per week? _____ Intensity: High Medium Low

Does your child/adolescent have any drug/food allergies? Yes No Do not know If yes, specify: _____

Has your child/adolescent been diagnosed and/or currently being treated for any significant health problems?

Yes No Do not know If Yes, list conditions: _____

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

Has your child/adolescent had a significant appetite change over the past month? Yes No Do not know

Comments: _____

Check any eating problems you have observed: Dieting Excessive Exercise Unusual eating habits

If yes, describe: _____

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HEALTH AND WELLNESS HISTORY (Continued)

Has your child experienced any sleep disturbance in the past month? Yes No Do not know

If yes, describe: _____

Are childhood immunizations up to date? Yes No Do not know

Is your child/adolescent taking any medication (prescription, over-the-counter, vitamins, herbs, supplements) for emotional, learning, behavioral problems or other medical problems? Yes No Do not know

Medication/Purpose:	Medication/Purpose:	Medication/Purpose:
_____	_____	_____
_____	_____	_____

Please answer the following to the best of your knowledge about your child/adolescent:

- | | | | |
|--------------------------|------------------------------|-----------------------------|----------------------------------|
| sexually active | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| uses contraceptives | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| has history of pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| has history of abortion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| has fathered a child | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

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

If Yes, Describe: _____

BEHAVIORAL HEALTH HISTORY

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

Yes No Do not know If Yes, complete information below:

<u>Outpatient</u>		<u>Inpatient</u>	
Therapist/Program	Date	Hospital	Date
_____	_____	_____	_____
_____	_____	_____	_____

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

- Physically harmed another individual, pet, or small animal? Threatened to physically harm anyone?
 Started a fire? Run away from home?
 Talked about or attempted suicide? Cut or mutilated their body? None of the above

If Yes, Describe: _____

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BEHAVIORAL HEALTH HISTORY (Continued)

Has your child/adolescent ever experienced or witnessed:

- Domestic violence Rape/sexual assault Emotional abuse Physical abuse Sexual abuse
 Other significant trauma None of the above

If Yes, Describe: _____

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

- Adapting to changes Goal setting Attending to tasks Learning Decision making
 Performing Self Care (hygiene, grooming, bathing, etc.) Following a routine
 Problem Solving Other None of the above

If Yes, Describe: _____

CULTURAL/ETHNIC/SPIRITUAL

Cultural/ethnic/racial issues that need consideration? Yes No

If Yes, explain: _____

Religious/spiritual issues that need consideration? Yes No

If Yes, explain: _____

DEVELOPMENTAL HISTORY

Was the pregnancy, birth and delivery of this child/adolescent? Normal Problematic Do not know

If problematic, describe: _____

Overall, do you feel your child/adolescent developed at a rate that was: Slow Normal Rapid Do not know

During the first three years of life, did your child frequently exhibit any problematic behavior?

- Yes No Do not know

If yes, Describe: _____

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SIGNIFICANT EVENTS Check any which have occurred in your child/adolescent's life.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Change of school | <input type="checkbox"/> Death in family | <input type="checkbox"/> Divorce or separation | <input type="checkbox"/> Move to a new place |
| <input type="checkbox"/> Frightening experience for child/adolescent | <input type="checkbox"/> Loss of someone close to child/adolescent | | |
| <input type="checkbox"/> Serious illness or injury to family member/friend | <input type="checkbox"/> Other | <input type="checkbox"/> None of the above | |

EDUCATION

School presently attending _____ Grade _____

School related issues: (check all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Academic problems | <input type="checkbox"/> Met with school counselor | <input type="checkbox"/> Advanced a grade | <input type="checkbox"/> Peer relationships |
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Relationship with teacher(s) | <input type="checkbox"/> Behavior | <input type="checkbox"/> Required special help |
| <input type="checkbox"/> Detention | <input type="checkbox"/> Suspension/expulsion | <input type="checkbox"/> Held back a grade | <input type="checkbox"/> Tested by school psychologist |
| <input type="checkbox"/> Homework | <input type="checkbox"/> Transportation | | (ADD, ADHD, other) |
| <input type="checkbox"/> None of the above | | | |

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

FAMILY/CURRENT LIVING SITUATION

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

Name	Age	Relationship to child/adolescent

List sibling(s) not living in the household:

Name	Age	Relationship to child/adolescent

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FAMILY/CURRENT LIVING SITUATION (Continued)

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

- Child Care Providers Father Mother Stepfather Stepmother
 Siblings Step-Siblings Other None of the above

Explain: _____

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

- Yes No Do not know Explain: _____

FINANCIAL

Are there family financial concerns?

- Yes No Do not know

Explain: _____

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 Do not know

If Yes, Explain: _____

Has your child/adolescent ever experienced any of the following with his/her use of alcohol, tobacco, prescription medications or other drugs? Yes No Do not know

- Change in peers Relationship problems School problems Work problems
 Legal problems Stealing from family/friends Mood swings Emotional problems
 Giving up previously enjoyed activities Physical problems Withdrawal symptoms
 Memory lapse after use Increased frequency/quantity of use None of the above

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LEGAL

Has your child/adolescent ever had involvement with the legal system? Yes No Do not know

Explain: _____

Are there any legal problems having to do with other family members? Yes No Do not know

Explain: _____

Signature of Parent/Guardian Completing Form

Date

Reviewed/Updated by Clinician

Date

Reviewed/Updated by Clinician

Date