

Dr. Sharon Phillips, LLC
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(513) 785-0831

CHILD/ADOLESCENT ASSESSMENT (Rev. 4/19)
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Name: _____ Date of Birth: _____

Date: _____

School: _____ Grade: _____

CURRENT SITUATION:

Briefly describe your reason for seeking help: _____

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

PRENATAL/BIRTH HISTORY:

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

Did child's mother use any of the following during pregnancy?

_____ Alcohol _____ Marijuana _____ Cocaine/Crack _____ Caffeine
_____ Cigarettes _____ Prescription drugs (list): _____
_____ None of the above _____ Do not know

Any medical complications during pregnancy: _____ Yes _____ No

Comments: _____

Length of pregnancy in months or weeks if known: _____

Birth Weight _____ lb. _____ oz.

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

<input type="checkbox"/> Baby given oxygen	<input type="checkbox"/> Incubator	<input type="checkbox"/> Rashes
<input type="checkbox"/> Baby on heart monitor	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Birth defects
<input type="checkbox"/> Problems breathing	<input type="checkbox"/> Problems eating/digestion	<input type="checkbox"/> Problems sucking
<input type="checkbox"/> Blood transfusions (baby)	<input type="checkbox"/> Delivery aided by instrument	<input type="checkbox"/> Cesarean section

EARLY DEVELOPMENT:

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

- Walking at _____ months
- Talking (single words) at _____ years
- Talking (short sentences) at _____ years
- Toilet training: daytime at _____ years; nighttime at _____ years

Overall, you feel your child developed at the following rate: _____ Slow _____ Normal _____ Rapid
Comments: _____

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

<input type="checkbox"/> Accident prone behavior	<input type="checkbox"/> Avoidance of cuddling	<input type="checkbox"/> Colic
<input type="checkbox"/> Destructive behavior	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Extreme mood changes
<input type="checkbox"/> Feeding problems	<input type="checkbox"/> Hand banging	<input type="checkbox"/> Lack of coordination
<input type="checkbox"/> Overactive behavior	<input type="checkbox"/> Problems with sleeping/waking patterns	
<input type="checkbox"/> Restless behavior	<input type="checkbox"/> Self-hurting behavior	<input type="checkbox"/> Severe temper tantrums
<input type="checkbox"/> Unresponsive to discipline	<input type="checkbox"/> Withdrawn behavior	<input type="checkbox"/> None of the above

Comments: _____

SEXUALITY:

Is your child/adolescent: _____ Prepubescent _____ Pubescent
For females, menstruation began at age _____ _____ Not yet began menses

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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: _____

HEALTH/MEDICAL HISTORY:

Primary Care Physician/Pediatrician _____

Current: Height _____ Weight _____

Does your child 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 have an eating or sleeping problem? (Check all that apply)

_____ Dieting	_____ Overeats	_____ Picky eater	_____ Refuses to eat
_____ Recent weight gain	_____ Vomiting	_____ Bedwetting	_____ Soiling
_____ Recent weight loss	_____ Does not want to sleep alone	_____ Difficulty falling asleep	
_____ Sleeps too much	_____ Trouble staying asleep	_____ Very restless at night	
_____ Nightmares	_____ Other _____	_____ None of the above	

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Have you ever tried sleeping aids for your child? (e.g. Melatonin, Benadryl)
 Please comment: _____

How would you describe the nutritional value/balance of your child's diet? _____ Good _____ Fair _____ Poor

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

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer/Leukemia |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fever Above 105 | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Musculo-Skeletal Condition | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> None of the Above | |

Comments: _____

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

Is your child taking any medications, either prescription or over-the-counter? Yes No
 If yes, please list all medications:

Medication/purpose	Dosage/times per day	For how long?	Does your child take it consistently?

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Has your child had prior mental health services, counseling, or alcohol/drug treatment? _____ Yes _____ No

If yes, please list names and dates below:

OUTPATIENT		INPATIENT	
THERAPIST OR PROGRAM NAME	DATE	HOSPITAL	DATE

Is there any history of emotional or mental problems in your child's blood relatives? _____ Yes _____ No

If yes, please explain: _____

Has anyone among your child's blood relatives had problems with alcohol or other drug use? _____ Yes _____ No

If yes, please explain: _____

LEGAL:

Has your child ever had involvement with the legal system? _____ Yes _____ No

Are there any legal problems having to do with other family members: _____ Yes _____ No

Comments: _____

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SIGNIFICANT EVENTS:

Has your child ever: (Check all that apply)

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

Comments: _____

Has your child experienced any of the following? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Change of school | <input type="checkbox"/> Death of family member or friend |
| <input type="checkbox"/> Divorce or separation | <input type="checkbox"/> Frightening experience for child/adolescent |
| <input type="checkbox"/> Move to a new place | <input type="checkbox"/> Serious illness or injury to family member/friend |
| <input type="checkbox"/> Loss of someone close | <input type="checkbox"/> Other |

Comments: _____

Has your child ever experienced or witnessed:

- | | | |
|--|--|---|
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Emotional abuse |
| <input type="checkbox"/> Rape/sexual assault | <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Other significant trauma |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> None of the above | |

Please comment: _____

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ACTIVITIES OF DAILY LIVING:

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Adapting to changes | <input type="checkbox"/> Attending to tasks | <input type="checkbox"/> Decision making |
| <input type="checkbox"/> Following a routine | <input type="checkbox"/> Goal setting | <input type="checkbox"/> Problem solving |
| <input type="checkbox"/> Performing self-care (hygiene, grooming, bathing, etc.) | | |
| <input type="checkbox"/> None of the above | | |

Comments: _____

EDUCATION:

School related issues: (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Academic problems | <input type="checkbox"/> Advanced a grade | <input type="checkbox"/> Attendance |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Frequent detentions | <input type="checkbox"/> Held back a grade |
| <input type="checkbox"/> Homework | <input type="checkbox"/> Met with school counselor | <input type="checkbox"/> Peer relationships |
| <input type="checkbox"/> Relationship with teacher | <input type="checkbox"/> Required special help | <input type="checkbox"/> Suspension/expulsion |
| <input type="checkbox"/> Tested by school psychologist | <input type="checkbox"/> Transportation | <input type="checkbox"/> School refusal |
| <input type="checkbox"/> None of the above | | |

Comments: _____

Does your child have an IEP or 504 Plan? Yes No

FAMILY HISTORY:

Custody Status: Birth Parents Mother only Father only
 Shared Parenting Adopted: Age of Adoption _____
 Guardian – Please specify: _____

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How would you describe the relationship between the father and the mother of your child?

Is your child experiencing any problems in relationships with: (Check all that apply)

Father Mother Siblings
 Stepfather Stepmother Step-siblings
 Child care providers Other: _____
 None of the above

Comments: _____

If child's parents are separated or divorced, please also complete the following questions:

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

Are there any legal issues related to your divorce? (e.g. restraining order, supervised visitation)

Yes No

If yes, please comment: _____

****For our records, please bring with you a copy of the custody agreement and parenting plan.****

ALCOHOL AND DRUG:

Describe what you know about your child or adolescent's use of:

- Alcohol _____
- Drugs _____
- Tobacco _____

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CULTURAL/ETHNIC/SEXUAL/SPIRITUAL:

Cultural/ethnic/racial issues that need consideration: _____

Sexual orientation issues that need consideration: _____

Religious/spiritual issues that need consideration: _____

Please add any additional information which you feel may be useful:

Thank you for providing this information.

Parent/Guardian Signature completing this form _____ Date _____

Reviewed by Dr. Sharon Phillips _____ Date _____