Dr. Sharon M. Phillips & Associates, LLC
8050 Beckett Center Drive, Suite 216
West Chester, Ohio 45069
(513) 860-0801

CHILD/ADOLESCENT ASSESSMENT (Rev. 2/12)

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)

_____ Baby given oxygen	_____ Incubator	_____ Rashes
_____ Baby on heart monitor	_____ Jaundice	_____ Birth defects
_____ Problems breathing	_____ Problems eating/digestion	_____ Problems sucking
_____ Blood transfusions (baby)	_____ Delivery aided by instrument	_____ 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)

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_____ Unresponsive to discipline	_____ Withdrawn behavior	_____ None of the above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

_____ ADHD	_____ Anemia	_____ Asthma	_____ Cancer/Leukemia
_____ Cerebral Palsy	_____ Diabetes	_____ Ear Infections	_____ Encephalitis
_____ Epilepsy	_____ Fever Above 105	_____ Hearing Problems	_____ Heart Problems
_____ Hydrocephalus	_____ Lead Poisoning	_____ Loss of Consciousness	_____ Meningitis
_____ Mononucleosis	_____ Musculo-Skeletal Condition		_____ Seizures
_____ Vision Problems	_____ Other: _____		_____ 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)

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

Comments: _____

Has your child ever experienced or witnessed:

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

Please comment: _____

_____

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ACTIVITIES OF DAILY LIVING:

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

_____ Adapting to changes _____ Attending to tasks _____ Decision making
_____ Following a routine _____ Goal setting _____ Problem solving
_____ Performing self-care (hygiene, grooming, bathing, etc.)
_____ None of the above

Comments: _____

EDUCATION:

School related issues: (Check all that apply)

_____ Academic problems _____ Advanced a grade _____ Attendance
_____ Behavior _____ Frequent detentions _____ Held back a grade
_____ Homework _____ Met with school counselor _____ Peer relationships
_____ Relationship with teacher _____ Required special help _____ Suspension/expulsion
_____ Tested by school psychologist _____ Transportation _____ School refusal
_____ 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
_____ Joint Custody _____ 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: _____

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

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: _____

_____

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

<u>ALCOHOL AND DRUG</u>:

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 Clinician _____ Date _____

Reviewed by Clinician _____ Date _____