COMPREHENSIVE CLINICAL ASSESSMENT & INTAKE – Child/Adolescent

Child's Name ________________________________ DOB __________ Date __________
Medicaid # _____________________________ County __________________ Chart # ___________
Gender: __M __F Ethnicity: __White; __ Black; __ Biracial; __ Hispanic; __ Asian; __ Other
Individuals participating in assessment: ____

Responsible Party Information

Responsible Party Name ____
Relationship to client ______________________
What is the best way to contact responsible party? ____
Current custody status: ___ Parents ___ Sole Parental Custody ___ Joint Legal Custody
___ DSS Custody ___ Other: _________________________________
List all persons who may be bringing this child to therapy sessions ______________________________
____

Household Information

Client's Address ____
Client's current living situation:
___ At home with parents/guardians ___ With other family ___ Foster care
___ Residential placement ___ Other (explain) ________________________________

Please list all members of the household:

Name	Relationship to Client
____	_________________
____	_________________
____	_________________
____	_________________
____	_________________
____	_________________
____	_________________

Please list any other significant family members who do not live with client: _______________________
____

School Information

School Name ____
Teacher Name(s) ____
Grade Level _______ Academic Performance: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing
Behavior in school: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing
IEP in place? ___ No ___ Yes (explain:) ____

Client: ______________________________	Chart #: ____________________
Medicaid #: ___________________________	DOB: ______________________

Developmental History

Was your child: ___ Planned ___ Breast Fed ___ In Day Care
___ Unplanned ___ Bottle Fed ___ Kept at Home
___ Exposed to medications/drugs/alcohol in the womb
___ Difficult or high-risk pregnancy or delivery

At what age did your child: Talk _________ Walk __________ Potty Train __________

Describe any developmental delays ____
____

Medical History Has your child experienced any of the following? (please explain)

___ Childhood trauma (Explain) ______________________________________
___ Severe illness, injury, surgery ______________________________________
___ Allergies (foods, drugs, substances) ______________________________________
___ Chronic medical problems ______________________________________
___ Significant family medical history ______________________________________
___ Significant family mental health history ______________________________________
___ Prior mental health diagnosis ______________________________________
___ Prior developmental diagnosis ______________________________________

Primary care physician ____

Current medications Name Dosage

________________________________ __________________
____
____
____

Treatment History

Please list all mental health treatment or hospitalizations

Facility/Therapist	Purpose	Current	Past
____________________	___________________________	_______	_______
____________________	___________________________	_______	_______
____________________	___________________________	_______	_______

Response to Treatment: ____

Other agency services/relationships in the last six months:

___ Child Protective Services ___ Justice System ___ Other: ________________
___ Other DSS Services ___ Disability/Social Security ___ Other: ________________
___ Occupational Therapy ___ Speech therapy ________________________

Client: ______________________________	Chart #: ____________________
Medicaid #: ____________________________	DOB: ____________________

Social/Family Information

Religious preference ____

Involved in local church? ___ No ___ Yes: ________________________________

Normal bedtime: __________ Number of hours usually slept: ________________

Where does your child sleep? _______________________________________

How is your child usually disciplined? _________________________________

What is your child's diet like? _____________________________________

Our household is usually (check all that apply)

___ Quiet ___ Calm ___ Highly structured ___ Lots of conflict

___ Noisy ___ Active/Busy ___ More relaxed/unstructured ___ Tense

What activities does your child enjoy?

___ Video games ___ Telephone ___ Sports

___ TV/Movies ___ Reading ___ Shopping

___ Internet/computer ___ Art/Crafts ___ Playing outside

___ Being with friends ___ Playing with toys ___ Other ____________________

Is there anything else you would like for us to know about your child's home life? ______________

____

Current Treatment Focus

What brings you and your child to our office today? _______________________

____

____

____

What services are you seeking:

___ Individual Therapy ___ Psychological/Educational Testing

___ Family Therapy ___ Psychiatric Services or Medication Management

___ Other (explain): ____

I/we would like to address the following: (check all that apply)

___ My child's mood or emotional state ___ My child's behavior

___ My child's school performance ___ My child's sleep, eating, or physical concerns

___ My child's cognitive/mental functioning ___ My child's relationships with family or peers

___ Parenting ___ Family relationships

___ Divorce ___ Other: ____________________________

___ Abuse or neglect

Client: ______________________________	Chart #: ____________________
Medicaid #: ___________________________	DOB: ______________________

Substance Use History

Alcohol ____

Illegal Drugs ____

Prescription Drugs ____

Other ____

Child Assessment: Please check all of the following that currently apply to your child.
Please indicate past concerns with the letter "P".

____ Anxiety	____ Hurts others	____ Hyperactive
____ Depressed mood	____ Lying	____ Attention problems
____ Panic attacks	____ Stealing	____ Worries all the time
____ Racing thoughts or speech	____ Destroying property	____ Impulsive
____ Obsessions/Compulsions	____ Defiance	____ Low self-esteem
____ Excessive fears or phobias	____ Blames others for mistakes	____ Suicidal thoughts
____ Dissociative states	____ Angry/resentful	____ Suicide attempts
____ Touchy/irritable	____ Lack of conscience	____ Self-mutilation
____ Nightmares	____ Bizarre behavior	____ Sexually active / acting out
____ Sleep problems	____ Clingy	____ Difficulty with change
____ Bedwetting or incontinence	____ Separation anxiety	____ Needs predictability/routine
____ Tantrums or "meltdowns"	____ Seems to overreact	____ Unexplainable mood shifts
____ Difficult to parent	____ Parent feels overwhelmed	____ Running away
____ Conflicting parenting styles	____ Argues with adults	____ Deliberately annoys people
____ Parental marital problems	____ Doesn't seem to listen	____ Takes excessive risks
____ Adopted or in foster care	____ Seems adultlike or older	____ Seems younger than age
____ Lots of physical complaints	____ Life has been unstable	____ Life changes pending

How did you hear about us?

___ Yellow Pages	___ Attorney: ____________________
___ Friend/Client	___ Doctor: ____________________
___ Internet	___ Other agency: ____________________
___ Court-ordered	___ Other: ____________________

Client: ______________________________	Chart #: ____________________
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To Be Completed By Therapist

Based on the assessment, the recommended treatment is:

☐ None	☐ Client Declined	☐ Community Resources
☐ Educational Services	☐ Financial	☐ Legal
☐ Medical/Physical	☐ Substance Abuse Treatment	☐ Twelve-step Program
☐ Psychiatric Assessment	☐ Psychological Testing	☐ Social Services
☐ Inpatient MH Treatment	☐ Outpatient MH Treatment	☐ Other: __________________

I certify that the information provided above is correct to the best of my knowledge, and that I am authorized to provide such information on behalf of this client.

____ ______________________

Signature of Legally Responsible Person Date

____ ______________________

Signature of Therapist Completing Assessment Date