COMPREHENSIVE CLINICAL ASSESSMENT & INTAKE – Child/Adolescent

Crossroads COUNSELING CENTER

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 school performance
___ My child's cognitive/mental functioning
___ Parenting
___ Divorce
___ Abuse or neglect
___ My child's behavior
___ My child's sleep, eating, or physical concerns
___ My child's relationships with family or peers
___ Family relationships
___ Other: _____

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
___ Friend/Client
___ Internet
___ Court-ordered
___ Attorney: _____
___ Doctor: _____
___ Other agency: _____
___ Other: _____

Client: _____	Chart #: _____
Medicaid #: _____	DOB: _____

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

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
☐ Psychiatric Treatment	☐ Outpatient MH Treatment	☐ Other: _____
☐ Inpatient MH Treatment		