

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 #: _____
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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 #: _____
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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)

- | | | | |
|--------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Calm | <input type="checkbox"/> Highly structured | <input type="checkbox"/> Lots of conflict |
| <input type="checkbox"/> Noisy | <input type="checkbox"/> Active/Busy | <input type="checkbox"/> More relaxed/unstructured | <input type="checkbox"/> Tense |

What activities does your child enjoy?

- | | | |
|---|--|--|
| <input type="checkbox"/> Video games | <input type="checkbox"/> Telephone | <input type="checkbox"/> Sports |
| <input type="checkbox"/> TV/Movies | <input type="checkbox"/> Reading | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Internet/computer | <input type="checkbox"/> Art/Crafts | <input type="checkbox"/> Playing outside |
| <input type="checkbox"/> Being with friends | <input type="checkbox"/> Playing with toys | <input type="checkbox"/> 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:

- | | |
|---|--|
| <input type="checkbox"/> Individual Therapy | <input type="checkbox"/> Psychological/Educational Testing |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Psychiatric Services or Medication Management |
| <input type="checkbox"/> Other (explain): _____ | |

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

- | | |
|--|---|
| <input type="checkbox"/> My child's mood or emotional state | <input type="checkbox"/> My child's behavior |
| <input type="checkbox"/> My child's school performance | <input type="checkbox"/> My child's sleep, eating, or physical concerns |
| <input type="checkbox"/> My child's cognitive/mental functioning | <input type="checkbox"/> My child's relationships with family or peers |
| <input type="checkbox"/> Parenting | <input type="checkbox"/> Family relationships |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Abuse or neglect | |



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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".

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

How did you hear about us? Yellow Pages Attorney: _____

Friend/Client Doctor: _____

Internet Other agency: _____

Court-ordered Other: _____



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I certify that the information provided in this document is correct to the best of my knowledge.

x _____
Signature of Parent/Guardian/Legal Responsible Party

x _____
Date

TO BE COMPLETED BY THERAPIST

Based on the assessment, the recommended treatment is:

<input type="checkbox"/> None	<input type="checkbox"/> Client Declined	<input type="checkbox"/> Community Resources
<input type="checkbox"/> Educational Services	<input type="checkbox"/> Financial	<input type="checkbox"/> Legal
<input type="checkbox"/> Medical/Physical	<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Twelve-step Program
<input type="checkbox"/> Psychiatric Assessment	<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Social Services
<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Outpatient MH Treatment	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Inpatient MH Treatment		

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge.

x _____
Signature of Therapist Completing Assessment

x _____
Date