

Assessment - Youth Report

Date of Birth: _____ Age: _____

Child's Name: _____
Chart No.: _____
Date: _____

General

1. Briefly explain why you are seeking treatment for your child:

2. How long has this been a problem? _____

3. What have you done to try and correct the problem up to this point?

4. Has your child ever been in counseling before (mental health, chemical dependency or hospitalizations)? No Yes: If yes please explain.

Mental Health: _____

Chemical Dependency: _____

Hospitalizations: _____

5. Who lives in the household and what is their relationship to your child?

Name	Age	Relationship to your child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Who is primarily responsible for the care of your child? List all that apply.

Name	Age	Relationship to your child
_____	_____	_____
_____	_____	_____
_____	_____	_____

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7. What are the most common disciplinary techniques used in the household? (Verbal reprimands, yelling, ignoring, time-out, grounding, removal of privileges, spanking, etc.)

8. Are discipline techniques used consistently and with good follow-through?

No Yes

9. Are current disciplinary techniques effective at controlling undesirable behaviors?

No Yes

10. Does your child respond to one parent or care-taker's disciplinary measures better than an other?

No Yes: If yes, who _____

11. Has your child experienced any of the following?

<input type="checkbox"/> Parental Divorce	<input type="checkbox"/> Parental Separation	<input type="checkbox"/> Death of a Parent
<input type="checkbox"/> Death of a Sibling	<input type="checkbox"/> Death of a Grandparent	<input type="checkbox"/> Death of a Close Friend
<input type="checkbox"/> Financial Problems	<input type="checkbox"/> Parental Alcoholism	<input type="checkbox"/> Parental Drug Abuse
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Verbal Abuse
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Family Bankruptcy	<input type="checkbox"/> Prolonged Marital Discord

12. Has any member of your family ever been diagnosed with a mental illness or substance abuse problem including alcoholism. (This would include extended family such as grandparents and aunts and uncles.)

No Yes: If yes, please provide further details.

13. Was your child born premature?

No Yes: If yes, please provide details.

14. Birth Weight: _____ lbs. _____ oz.

15. Approximately what age did your child first begin the following:

Walking _____ Talking _____ Toileting _____

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Medical History

16. Does your child have any immediate health problems (colds, injuries)?

No Yes: If yes, please explain.

17. Does your child have any chronic (longer-term) health problems (asthma, seizures, allergies, pain)?

No Yes: If yes, please explain.

18. Does your child have any developmental disorders (mental retardation, learning disabilities, hearing disabilities, speech problems, etc.)?

No Yes: If yes, please explain.

19. Has your child ever sustained any serious head injuries (been knocked unconscious, been in a car accident, fight, etc.)?

No Yes: If yes, please explain.

20. Is your child currently under the care of a physician?

No Yes: If yes, who and for what conditions.

Doctors Name _____ Phone _____

Conditions being treated: _____

21. Is your child currently on any medications?

No Yes: If yes, please list:

Medication	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____

22. Please list all previous mental health medications:

Medication	Dosage	Date Started	Date Stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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23. Please rate the nutritional value of your child's total daily diet intake. Good ___ Fair ___ Poor ___

If Fair or Poor, please explain: _____

Please check any of the following that apply.

- | | |
|--|---|
| <input type="checkbox"/> Significant weight gain/loss in the last six months | <input type="checkbox"/> Problems chewing or swallowing |
| <input type="checkbox"/> Food/drug allergies | <input type="checkbox"/> Dieting |
| <input type="checkbox"/> Overeating or eating too little | |

If any box is checked please explain: _____

24. Does your child have any functional limitations that affect daily living (e.g. physical impairments, problems with self-care or grooming)? Yes ___ No ___

If Yes please explain: _____

25. Has your child had a recent vision exam?

- No Yes: If yes, please describe results. _____

26. Has your child had a recent hearing exam?

- No Yes: If yes, please describe results. _____

Educational History

27. What grade is your child currently in? _____

28. Where does your child attend school? _____

29. Circle any grade(s) failed. K 1 2 3 4 5 6 7 8 9 10 11 12 None N/A

30. Circle any grade(s) skipped. K 1 2 3 4 5 6 7 8 9 10 11 12 None N/A

31. What grades does your child normally get in school? (Circle all that apply)

A B C D F

32. Have there been any tendencies toward improving or deteriorating school performance over the years?

- No Yes: If yes, please explain.

33. What are your child's strongest subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies N/A

34. What are your child's weakest subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies N/A

Child's Name: _____
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36. Has your child ever been:

- | | | | | |
|------------------------|--------------------------|----|--------------------------|-----|
| Reprimanded at school: | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Served detention: | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Been suspended: | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Been expelled: | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |

If Yes was checked, please explain why _____

37. Has the school ever performed psychological or educational testing with your child?

- No Yes: If yes, why and what was the outcome.
-

Social Development

38. Does your child have many friends?

- No Yes

39. Does your child make friends easily?

- No Yes

40. What are the most common activities that your child engages in? (Bike riding, playing with friends, watching T.V., etc.) _____

Behavioral Assessment

41. Has your child ever been in trouble with the legal authorities?

- No Yes: If yes, please explain.
-

42. To your knowledge, does your child use tobacco?

- No Yes: If yes, how often, how much and for how long?
-

Client name: _____
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43. To your knowledge, does your child drink alcohol?

No Yes: If yes, how often, how much and for how long? _____

When was the last time? _____

How many drinks? _____

44. What problems has your child suffered as a result of his/her drinking? (Check all that apply.)

- Arrest DUI Peer Problems
 Public Intoxication Financial Problems Arguments
 None of the Above

45. To your knowledge, has your child ever tried any drugs?

No Yes: If yes, what drug? _____

46. To your knowledge, does your child use any drugs?

No Yes: If yes, how often and for how long? _____

When was the last use? _____

What drug was used and how much? _____

47. Which of the following drugs has your child used in the last 6 months?

- Marijuana / "Pot" Cocaine Pain Killers
 LSD / "Acid" Amphetamines / "Speed" Sedatives / "Downers"
 Inhalants / "huffing" Other _____ None of the Above

48. To your knowledge, is your child sexually active?

No Yes

49. Does your child have concerns about his/her sexual orientation or sexual experiences?

No Yes

50. Is your child pregnant or the parent of a child?

No Yes: If yes, please provide further details.

51. Who has legal custody of your child?

- Both Parents Mother only Father only Other guardian

If Other guardian, please indicate name: _____

Assessment - Youth

YOUTH SYMPTOM CHECK LIST:

- 0) None:
- 1) Mild: Some Times/Some Concern/Brief Episode
- 2) Moderate: Often/Significant Worry/Lasts for a While
- 3) Severe: Very Often/High Intensity/Continuous

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Rather be alone	
Refuses to talk	
Secretive	
Shy, Timid	
Irritable	
Sulks	
Underactive	
Sad	
Lonely	
Cries a Lot	
Fears Going to School	
Needs to be Perfect	
Feels Unloved	
Feels Picked On	
Feels Worthless	
Nervous, Tense	
Fears Animals, Places, Situations	
Anxious	
Self Conscious	
Worries	
Over Conforms	
Feelings Easily Hurt	
Anxious To Please	
Afraid to Make Mistakes	
Trouble With Sleep	
Anxious if Separated from	
Nightmares	
Failure to Speak in Some Settings	
Changes/Problems with Eating	
II	
Feels Dizzy	
Overtired	

Aches, Pains	
Headaches	
Nausea	
Rashes	
Stomachaches	
Vomiting	
Wets Self Day or Night	
BM Accidents or Smears BM	
III	
Acts too Young	
Too Dependent	
Poor Peer Relations	
Gets Teased	
Clumsy	
Prefers Younger Children	
Overweight	
Accident Prone	
IV	
Concentration Problems	
Difficulty Sitting Still	
Restless	
Energetic	
Talks Excessively	
Difficulty Waiting Turn	
Interrupts Others	
Looses Things	
Easily Distracted	
Forgetful	
Daydreams	
Impulsive	
Fidgets	
Difficulty Following Directions	
Messy Work	

Makes Careless Mistakes	
Poor Listening Skills	
Poor Organizational Skills	
Twitches	
Hums, Odd Noises	
V	
Can't Get Mind Off Thoughts	
Hears Things	
Sees Things	
Repeats Acts	
Strange Behaviors	
Strange Ideas	
VI	
Argues	
Braggs	
Mean to Others	
Demands Attention	
Destroys Own/Other's Things	
Disobedient at School	
Disobedient at Home	
Jealous	
Fights	
Attacks People	
Screams	
Shows Off	
Stubborn	
Easily frustrated	
Sudden Mood Changes	
Temper Tantrums	
Threatens	
Disturbs Others	
Disrupts Class	
Explosive	

