St. Elizabeth Healthcare
Employee Assistance Program

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

Revised 06/02

Client name:	______________________
Chart number:	______________________
Date:	______________________

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 another?

☐ **No** ☐ **Yes:** If yes, who___________

11. Has your child experienced any of the following?

☐ Parental Divorce	☐ Parental Separation	☐ Death of a Parent
☐ Death of a Sibling	☐ Death of a Grandparent	☐ Death of a Close Friend
☐ Financial Problems	☐ Parental Alcoholism	☐ Parental Drug Abuse
☐ Domestic Violence	☐ Physical Abuse	☐ Verbal Abuse
☐ Sexual Abuse	☐ Family Bankruptcy	☐ 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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Child's Name: ____________________
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Date: ____________________

St. Elizabeth Medical Center
Employee Assistance Program

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
____________________	__________	__________	__________
____________________	__________	__________	__________
____________________	__________	__________	__________
____________________	__________	__________	__________

Client name: _______________________
Chart number: _______________________
Date: _______________________

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.

- ☐ Significant weight gain/loss in the last six months
- ☐ Problems chewing or swallowing
- ☐ Food/drug allergies
- ☐ Dieting
- ☐ 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:	______________________
Chart No.	______________________
Date:	______________________

36. Has your child ever been:

Reprimanded at school:	☐	**No**	☐	**Yes**
Served detention:	☐	**No**	☐	**Yes**
Been suspended:	☐	**No**	☐	**Yes**
Been expelled:	☐	**No**	☐	**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:	______________________
Chart number:	______________________
Date:	______________________

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

Child's Name:	
Chart No.	
Date:	

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

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	
Brags	
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	

VII	
Lacks Guilt	
Bad Peer Group	
Lies	
Prefers Older Kids	
Runs Away	
Sets Fires	
Steals	
Swearing/Obscenity	
Skips School	
Alcohol Use	
Drug Use	

Vandalism	
Too Sexual	
VIII	
Talks About Killing Self	
Past Suicide Attempts	
Hits/Hurts Self	
Talks About Hurting Others	
Hits/Hurts Others	
Hurts Animals	
Other:	
Other:	
Other:	