Systemic Perspectives, Inc.
CHILD/ADOLESCENT ASSESSMENT

This confidential information is for the use of your counselor. Each family member seen in therapy should complete this form.

NAME: _____ Today's Date:_____

Name of Primary Physician(s) _____

Current Prescription Drugs _____

Would you like us to contact your child's doctor(s)? Yes ___ No ___

Check any of the following conditions for which your child has ever received treatment:

ADD/ADHD	( )	Head Injury	( )
Alcohol/Drug Problems	( )	Hearing Problems	( )
Allergies	( )	Heart Disease	( )
Arthritis	( )	High Blood Pressure	( )
Asthma	( )	Hypoglycemia	( )
Back Trouble	( )	Pregnancy	( )
Cancer	( )	Seizure Disorders	( )
Chronic Pain	( )	Skin Problems	( )
Depression/Anxiety	( )	STD's	( )
Diabetes	( )	Thyroid Disorder	( )
Digestive Disorders	( )	Vision Problems	( )
Headaches	( )	Other _____	
		_____	

<u>Sources of Stress</u>

Check the events / problems that are creating stress for your child at the present time:

( ) School	( ) Verbal Abuse	( )
( ) Peers	( ) Physical Abuse	Other_____
( ) Family	( ) Death / Loss	_____
( ) Community Violence	( ) Illness	_____
( ) Sexual Abuse		

Do you know of or suspect your child's use of?:

Alcohol: Know ( ) Suspect ( ) Nicotine : Know ( ) Suspect ( )

Caffeine: Know ( ) Suspect ( ) Unprescribed Drugs: Know ( ) Suspect ( )

Do you know of or suspect any sexual activity by your child? Know ( ) Suspect ( )

Patient Name _____

Check any of the following symptoms your child has shown:

Bed-wetting ___
Temper tantrums ___
Night terrors ___
Too much sleeping ___
Irritable/grouchy ___
Risky behaviors ___
Talking too much or too fast ___
Poor attention span ___
Sexual behaviors ___
Hyperactive ___
Impulsive (reckless) ___
Tics ___
Mute (won't talk) ___
Blank staring ___
Aggressive/violent ___
Fire starting ___
Stealing ___
Odd behavior ___
Hearing voices ___
Hurts other people ___
Suicidal thinking or attempts ___
Damaging property ___
Does not feel guilt ___
Running away ___
Skipping school ___

Excessive waking at night ___
Tired all the time ___
Little need for sleep ___
Lying ___
Drug or alcohol use ___
Cruelty to animals ___
School suspension or expulsion ___
Unreasonably happy ___
Long periods of sadness ___
Cries easily ___
Difficulty separating ___
Poor frustration tolerance ___
High anxiety ___
Withdrawn ___
Over-confident ___
Poor self-esteem ___
Too much guilt ___
Difficulty with friendships ___
Obsessive (unwelcome) thoughts ___
Compulsive (repeated) behaviors ___
Changes in eating habits ___
Physical complaints ___
Self-harm or cutting ___
Paranoid thinking ___

What was your child's birth weight? _____ lbs _____ oz □ Unknown

Was delivery normal?
□ Yes □ Unknown □ No: specify _____

Did birth mother experience any physical or emotional problems during pregnancy?
□ No □ Unknown □ Yes: specify _____

Did birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?
□ No □ Unknown □ Yes: specify _____

Did the baby experience any problems immediately after birth?
□ No □ Unknown □ Yes: specify _____

Patient Name _____

Has your child ever required hospitalization?
□ No □ Unknown □ Yes: specify _____

Is there any history of physical, sexual or emotional abuse?
□ No □ Unknown □ Yes: specify _____

Is there a history of prolonged separations or traumatic events?
□ No □ Unknown □ Yes: specify _____

Have you ever believed your child was developing more slowly than other children in the following areas?

Physical ( )	Cognitive ( )	Emotional ( )
Speech ( )	Behavioral ( )	Social ( )

Has there been any history of involvement by? :
Dept. of Social Services
□ No □ Unknown □ Yes: specify _____
Dept. of Juvenile Services
□ No □ Unknown □ Yes: specify _____

Which school is your child currently attending? _____
Current grade _____

Would you like us to contact your child's school? Yes ___ No ___
Contact Person/Phone: _____

Is your child currently receiving special services in this school? □ No
□ Yes: specify _____

Has your child ever failed a class or been held back for academic reasons?
□ No □ Yes: specify grade:_____

Are there any diagnosed learning problems?
□ No □ Yes: specify _____