JESSICA LANG, LMFT

Child/Adolescent Assessment Form

Please provide the following information about your child:

Child/Adolescent Full Name:_____

Birth Date: _____ Today's Date _____

Gender (check all and any that apply):

I/My Child/teen consider myself/themself: □Male □Female □Transgender Male □Transgender Female □Other_____

[Transgender means a person whose gender identity is different from the gender assigned at birth]

Sexual Orientation:
I/My Child/teen consider myself/themself: □Straight/Heterosexual □Bisexual □Gay □Lesbian □Other_____

Preferred Pronoun for you/your child/teen (check all and any that apply):
□He □She □They □Ze

Parent(s)/Caregiver(s) Name:_____

1) <u>FAMILY CULTURAL AND/OR ETHNIC INFORMATION</u>

A) As a family, do you identify yourself with a particular cultural or ethnic group? ☐No☐Yes If Yes, please note cultural/ethnic identification and the influence or role it plays in family life._____

_____

B) What is the Religious/Spiritual Orientation of your family?

_____

C) How does your religious/spiritual orientation affect family life?

_____

_____

<u>2. **Please provide the following information about your child:**</u>

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A) Please state the problem(s) your child/adolescent is experiencing which led you to seek help.

_____

_____

_____

B) Did anyone suggest/require you to seek help for your child/adolescent?
☐NO☐YES If yes, who and for what reason(s) if different from the above reason?

_____

_____

C) SOCIAL/RECREATIONAL/STUDY TIME INFORMATION

How many hours per week does your child spend in social/leisure time activities?_____
Is your child involved in any organized sports or recreational activities?☐No☐Yes If Yes, please note what activities and how many hours per week._____
How many hours per week does your son/daughter study and/or do homework?_____

3. GENERAL BEHAVIOR: Please check any items below which describe your child/adolescent's typical behavior. That is, how he/she is most of the time.
☐Friendly/Outgoing ☐Shy ☐Easy-going/Calm ☐Irritable ☐Hardworking
☐Lazy ☐Prefers Company ☐Prefers to be Alone ☐Optimistic ☐Pessimistic
☐Caring ☐Uncaring ☐Cooperative ☐Stubborn ☐Confident ☐Expects Failure
☐Sharing ☐Selfish ☐Respectful ☐Defiant ☐Takes Risks ☐Cautious ☐Generally Happy ☐Generally Unhappy

4. PROBLEM BEHAVIORS: Please check any of the behaviors which occur excessively or frequently now and/or in the past.
☐Worries ☐Fears ☐Obsessive Thoughts ☐Compulsive/Repetitive Behavior
☐Accident Prone ☐Short Attention Span ☐Distractible ☐Impulsive
☐Hyperactive Problems ☐Speech Problems ☐Mood Swings ☐Tantrums, Angry Outbursts ☐Disruptive Behavior ☐Reckless/Careless Behavior ☐Argues
☐Defiant/Oppositional ☐Lies ☐Runs Away from Home ☐Steals ☐Destroys property ☐Sets Fires ☐Cruelty to Animals ☐Legal Problems ☐Skipping Classes/School ☐Learning Problems ☐Poor School Work ☐Bullies ☐Fights
☐Sadness ☐Depression ☐Crying Spells ☐Irritable ☐Withdrawn ☐Boredom
☐Decrease in Appetite ☐Increase in Appetite ☐Insomnia ☐Nightmares ☐Night

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terrors ☐Sleepwalking ☐Will Not Sleep Alone ☐Missing School Due to Illness ☐Frequent Physical Complaints ☐Odd Thoughts ☐Odd Behavior ☐Disturbing Thoughts

A) Has your child/adolescent ever talked about or attempted suicide?☐No☐Yes If Yes, when and what were the circumstances:_____

_____

B) Has your child/adolescent ever talked seriously about hurting or killing someone/something, or done so?☐No☐Yes If Yes, when and what were the circumstances?_____

_____

5. Family History:

A) The name of the child's parents/Guardian:

Mother(s):_____

Father(s):_____

B) Who has legal guardianship of your child?_____

C) Who does your child currently live with?

Names:_____Relationship to child:_____

D) Family History of Psychiatric conditions: Please check any family members with a history of difficulties in the areas noted.

Mother☐ Father☐ Siblings☐ Grandparents☐ Other Relatives☐

☐DEPRESSION ☐MANIA ☐ANXIETY☐PSYCHOSIS ☐ADHD ☐ALCOHOL/DRUGS

Please Explain:_____

_____

E) FAMILY MEDICAL HISTORY: Please check any family members with a history of difficulties in the areas noted.

CHRONIC NEUROLOGIC SEIZURE☐ THYROID☐ Cognitive Disabilities☐

Mother☐ Father☐ Siblings☐ Grandparents☐ Other Relatives☐

Please Explain:_____

_____

_____

6) BIRTH TO FIVE YEAR DEVELOPMENTAL HISTORY

- Mother's Pregnancy: ☐Normal ☐Complicated [Explain]:_____

_____

_____

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• Check any substances the biologic mother used during her pregnancy and comment on any item checked. ☐Tobacco ☐Alcohol ☐Drugs ☐Medications

_____

• Check any of the following that pertain to the biologic mother's delivery: ☐Full Term ☐Vaginal Delivery ☐Premature ☐C-Section ☐Fetal Distress
Please explain any complications._____

_____

• Child's condition at birth:☐Normal☐Abnormal If Abnormal, please explain._____

_____

• Birth Weight: _____ lbs. _____ oz.
• As an infant was your child/adolescent: ☐Easy to Manage ☐Irritable ☐Alert ☐Responsive ☐A Poor Eater
• At what age did your child:
• Sit: _____Walk without support:_____Talk:_____Use sentences:_____
• Toilet trained:_____Was toilet training easy or difficult?☐Easy☐Difficult
• Does your child/adolescent: ☐Bed wet ☐Daytime wet ☐Soil and/or has bowel movements in underclothing/in inappropriate places
Please comment on any checked item._____

_____

• By or before the time your child entered kindergarten did you, your child's physician or any of your child's preschool teachers have concerns about any of the following areas of development?
☐Language Development [Use of words and sentences] ☐Balance/Coordination ☐Speech Development [Pronunciation] ☐Behavior Problems ☐Fine Motor Development [pencil grip, coloring, cutting, etc.] ☐Vision ☐Intelligence ☐Hearing

7. SCHOOL HISTORY
What school does your child attend?_____

Address:_____Phone:_____

Fax:_____Principals Name:_____

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Current Grade:_____Teachers Name(s):_____

A) What does your child's teacher say about him/her?_____

_____

_____

B) Other schools attended (including Pre-school):_____

_____

C) Has your child ever repeated a grade? If so which one(s):_____

Has your child ever received special education services?_____

D) Has your child experienced any of the following problems at School?:

Fighting lack of friends drug/alcohol detention

Suspension learning disabilities poor attendance poor grades

Gang influence incomplete homework behavior problems

8. Medical History:

A) What is the name of your child's medical doctor:_____

B) Address:_____

C) Phone:_____ Fax:_____

D) Date of your child's last medical examination:_____

E) Did the child's biological mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:_____

_____

F) Did the child's biological mother have any problems during the pregnancy or at delivery? If so, Please describe them:_____

_____

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G) Has your child experienced any of the following medical problems?

A serious accident___ Hospitalization___ Surgery___ Asthma___

A head injury ___ High fever___ Convulsions/seizures___

Eye/ear problems___ Meningitis___ Hearing problems___

Allergies___ Loss of consciousness___ Other___

H) Please list any current medical problems or physical handicaps:_____

_____

I) Please list any medications your child takes on a regular basis:_____

_____

9. Other History:

A) Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so please describe:

_____

_____

_____

B) Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else? If yes please explain

_____

_____

_____

C) Has he/she ever purposely hurt himself or another? (If yes to either question please describe the situation):

_____

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_____

_____

D) Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

_____

_____

_____

E) Finally, what are some of the things that are currently stressful to your child and his/her family?

_____

_____

_____

F) Please describe any past counseling that either your child or any family member has had.

10. **SIGNIFICANT LIFE EVENTS:** Please check any of the following events which have occurred in your child/adolescent's life.

☐Change of residence ☐Change of schools ☐Change of custody ☐Marital conflict ☐Parents separated ☐Parents divorced ☐Parent visitation problems ☐Post divorce ☐Parent conflict ☐Parent(s) remarried ☐Step parent problems ☐Sibling birth ☐Acquiredstep sibling(s) ☐Family economic problems ☐Family jobproblems ☐Family substance abuse ☐Family gambling problems ☐Family psychiatric problems ☐Family chronicillness ☐Other family problems ☐Rejection by family member(s) ☐Abuse to self (verbal, physical, etc) ☐Witnessed abuse to others ☐Victim of abuse ☐Suffered/Witnessed significant Other severe fright or trauma ☐Death of family member or friend ☐Suicide of family member or friend ☐Death or pet ☐Other:_____

_____

Please Explain the check marks here:_____

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_____

_____

_____

_____

11. PREVIOUS PSYCHIATRIC AND/OR CHEMICAL/DEPENDENCY TREATMENT HISTORY: Has your child/adolescent received any psychiatric or chemical dependency treatment in the past?☐No☐Yes If Yes, please indicate in the space provided below.

TYPE OF TREATMENT iInpatient or Outpatient?) & DATE(S):_____

_____

_____

_____

TREATMENT FACILITY & THERAPIST

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