The Stern Center
for Developmental and Behavioral Health

CHILD/ADOLESCENT/FAMILY PSYCHOSOCIAL

Client Name: _____ **Date:** _____

Nickname/Preferred Name: _____ Preferred Pronouns: _____

Date of Birth: _____ Place of Birth _____ Age_____

Name of Parent(s)/Guardian(s): _____

Name of person filling out form & relation to client: _____

How did you hear about us? _____ Referral Source: _____

Reason for Assessment_____

Person(s) participating in todays assessment_____

Address (number and street) _____

(City) _____ (State) _____ (Zip code) _____

Telephone Number(s) _____ Email _____

Insurance information _____

Self-Identified Gender of Client _____ Sexual Orientation of Client _____

Race _____ Ethnicity _____ Religion (optional) _____

Are there any specific cultural considerations that would impact service delivery? Yes☐ No☐, If yes, please explain.

_____

Do you require any assistive devices (sight, hearing, mobility) in order for services to be delivered appropriately?

Yes☐ No☐ If yes, please explain: _____

Service Coordinator/ Case Manager Name & Phone Number? _____

CURRENT FAMILY COMPOSITION

Name	Relationship	Age	Occupation	Education	Quality of Relationship

Present home: ◉ renting ○ own ○ house ○ apartment

Biological Mother's Name:_____

Biological Father's Name:_____

Marital History of Parents:

Parents: ☐ unmarried
☐ married when _____ age _____ _____
☐ separated when _____
☐ divorced when _____
☐ deceased M or F F

Step-Parents: N/A ☐ No ☐ married when _____

Any relevant details: _____

Name of parent/guardian who has physical custody_____ Medical Rights _____

If child is adopted:

Age when child first in home: _____ Date of legal adoption: _____

What has the child been told? _____

Was the child ever placed, boarded, or lived away from the family? ☐ Yes ☐ No

Explain: _____

Please describe the child's relationship with immediate family members:_____

_____

Relationship with siblings:_____

_____

What are the major family stresses at the present time, if any? _____

_____

HEALTH OF FAMILY MEMBERS (excluding patient):

Name	Relationship	Type of Illness	When Occurred	Length
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Is there any history in the child's family of: ☐ Drugs ☐ Alcohol ☐ SI/HI ☐ Mental Health Diagnosis

(If yes, please explain): _____

_____

CHILD HEALTH INFORMATION

Note all health problems the child has had or has now:

	Age		Age
☐ High Fevers	_____	☐ Hearing Problems	_____
☐ Pneumonia	_____	☐ Weight Problems	_____
☐ Flu	_____	☐ Allergies	_____
☐ Encephalitis	_____	☐ Skin Problems	_____
☐ Meningitis	_____	☐ Asthma	_____
☐ Convulsions	_____	☐ Headaches	_____
☐ Unconsciousness	_____	☐ Stomach Problems	_____
☐ Concussions	_____	☐ Accident Prone	_____
☐ Head Injury	_____	☐ Anemia	_____
☐ Fainting	_____	☐ High or Low Blood Pressure	_____
☐ Dizziness	_____	☐ Sinus Problems	_____
☐ Tonsils Out	_____	☐ Heart Problems	_____
☐ Vision Problems	_____	☐ Hyperactivity	_____

Other:_____

Has the child ever been hospitalized: ☐ Yes ☐ No If yes, explain: _____

_____

Has the child ever been seen by a medical specialist: ☐ Yes ☐ No If yes, for what: _____

Is the child currently taking any medications? ☐ Yes ☐ No

Is the child/adolescent pregnant ☐ Yes ☐ No

If pregnant, is the child/adolescent receiving prenatal care? ☐ Yes ☐ No

Does the child receive care services such as Chiropractic, Yoga? ☐ Yes ☐ No

Medication & Dosage	Condition Prescribed For	Prescribed By

Please list any previous medications that have been discontinued. _____

_____

How effective do you believe previous/current medications address what they are prescribed for? _____

_____

Is the child taking any over the counter medication or supplements?_____

Recent Appetite change ☐ Yes ☐ No Weight change ☐ Yes ☐ No Sleep issues ☐ Yes ☐ No

Family Doctor: _____ Date of Last Physical: _____

PREGNANCY/DELIVERY:

Complications During Pregnancy or Birth: ☐ Yes ☐ No If Yes, Explain: _____

_____

Did the mother use alcohol/drugs during pregnancy: ☐ Yes ☐ No If Yes, Explain: _____

_____

DEVELOPMENTAL MILESTONES:

Age at which the child: Sat Up: ____ Crawled: ____ Walked: ____ Single Words: ____ Sentences: ____Toilet Trained: ____

Did the child have delays? ☐ Yes ☐ No If Yes, Please Explain: _____

_____

EDUCATIONAL HISTORY:

	Name of School	City/State	Dates Attended From	Dates Attended To	Highest Grade Completed
Preschool:	_____	_____	_____	_____	_____
Elementary:	_____	_____	_____	_____	_____
Junior High:	_____	_____	_____	_____	_____
High School:	_____	_____	_____	_____	_____

Types of Classes: ☐ Traditional ☐ Learning Support ☐ Emotional Support

If in supportive classroom, please explain: _____

_____

Did the child skip a grade: ☐ Yes ☐ No

Did the child repeat a grade: ☐ Yes ☐ No

If yes, which grade and reason for repeating _____

Does the child have any barriers to learning: ☐ Yes ☐ No

Does the child attend school on a regular basis: ☐ Yes ☐ No

If No, Please Explain: _____

Has the child ever been suspended or expelled: ☐ Yes ☐ No

If Yes, Please Explain: _____

How often does the school call to report problems that your child is having? _____

In school, how many friends does the child have: ☐ A lot ☐ A Few ☐ None

Does the child like school? ☐ Yes ☐ No

Does the child do well in school? ☐ Yes ☐ No

LEGAL INVOLVEMENT

Has there been Involvement with Child Protective Services? ☐ Yes ☐ No

If Yes, Please Explain: _____

Has there been Involvement with Children and Youth Services(CYS)? ☐ Yes ☐ No

If Yes, Please Explain:

_____

Has the child ever had involvement with the law: ☐ Yes ☐ No

If yes, Please Explain: _____

Has the child ever appeared in juvenile court: ☐ Yes ☐ No

If yes, Please Explain: _____

Has the child ever been on probation: ☐ Yes ☐ No

If Yes, Please Explain _____

EMPLOYMENT/VOLUNTEER

Has the child ever been employed or volunteered: ☐ Yes ☐ No

Job	Employer	How Long
_____	_____	_____
_____	_____	_____

Is the child enlisted in any military service? ☐ Yes ☐ No If yes, which branch and length of commitment: _____

_____

CHILD/CLIENT CONCERNS

Child Description of Presenting Problem:

_____

_____

_____

_____

How would you describe your current level of functioning in daily activities:_____

_____

How would you describe how you have adjusted psychologically and socially to your diagnosis and/or disorder?

_____

_____

How long have these problems occurred? (number of weeks, months, years)

_____

What happened that makes you seek help at this time? _____

_____

What are your expectations of your child? _____

What changes would you like to see in your child? _____

_____

What changes would you like to see in yourself? _____

_____

What changes would you like to see in your family? _____

_____

What are the strengths of the child and their family?_____

_____

What do you believe are your child's abilities and or interests?_____

_____

Presenting Problems: (check all that apply)

- ☐ Very Unhappy
- ☐ Irritable
- ☐ Temper Outbursts
- ☐ Withdrawn
- ☐ Daydreaming
- ☐ Phobic
- ☐ Fearful
- ☐ Clumsy
- ☐ Overactive
- ☐ Slow
- ☐ Short Attention Span
- ☐ Distractible
- ☐ Lacks Initiative
- ☐ Undependable
- ☐ Peer Conflict
- ☐ Impulsive
- ☐ Stubborn
- ☐ Disobedient
- ☐ Infantile
- ☐ Mean to Others
- ☐ Destructive
- ☐ Trouble with the Law
- ☐ Running Away
- ☐ Self Mutilating
- ☐ Head Banging
- ☐ Rocking
- ☐ Shy
- ☐ Strange Behavior
- ☐ Strange Thoughts
- ☐ Fire Setting
- ☐ Stealing
- ☐ Lying
- ☐ Sexual Trouble
- ☐ School Performance
- ☐ Truancy
- ☐ Bed Wetting
- ☐ Soiled Pants
- ☐ Eating Problems
- ☐ Sleeping Problems
- ☐ Sickly
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Suicide Talk

Previous Mental Health or D&A Treatment Services? ☐ Yes ☐ No

If Yes, What Services: _____

Previous Mental Health Diagnosis? ☐ Yes ☐ No

If Yes, Please Explain: _____

Has the Child witnessed or experienced a Traumatic Event ☐ Yes ☐ No

Traumatic or significant loss? ☐ Yes ☐ No

Community violence? ☐ Yes ☐ No

Medical trauma? ☐ Yes ☐ No

If Yes, Please Explain: _____

Has the child been a victim of physical, sexual or emotional abuse ? ☐ Yes ☐ No

If Yes, Please Explain _____

Has the child experienced neglect or out of home placement? ☐ Yes ☐ No

If Yes, Please Explain _____

Has the child been a victim of domestic violence? ☐ Yes ☐ No

If Yes, Please Explain _____

Has the child been a witness of domestic violence? ☐ Yes ☐ No

If Yes, Please Explain _____

If trauma has been identified is your child currently receiving services for their trauma? ☐ Yes ☐ No

If Yes, Please Explain _____

Does the child and/or family request a referral be made for trauma services? ☐ Yes ☐ No

If Yes, Please Explain _____

Previous Hospitalization? ☐ Yes ☐ No Number of Hospitalizations: _____

If yes, when & reason for Hospitalization: _____

Is There a History of Self-Harm or Suicidal Behavior? ☐ Yes ☐ No

If Yes, Please Explain _____

Has the child hurt others, destroyed property or been cruel to animals? ☐ Yes ☐ No

If Yes, Please Explain _____

Does the child or family have firearms? ☐ Yes ☐ No

If Yes, Please Explain how the firearms are stored _____

MISA SCREENING

Does the client use chewing tobacco, smoke cigarettes or vape? ☐ Yes ☐ No

If yes which ones and how often? _____

When did they first start? _____

Is the child or family interested in cessation services? ☐ Yes ☐ No

Does the Client use any illegal drugs? (Include any misuse of prescribed medications) ☐ Yes ☐ No

If Yes, Please List:_____

Does the client drink alcohol? ☐ Yes ☐ No

If yes, how much and how often? _____ When did the alcohol use start? _____

If a co -occurring disorder has been identified is your child currently receiving services for this? ☐ Yes ☐ No

If Yes, Please Explain _____

Does the child and/or family request a referral be made for co-occurring services? ☐ Yes ☐ No

If Yes, Please Explain _____

MENTAL STATUS EXAM

A. Appearance:

☐ WNL ☐ Unkempt ☐ Dirty ☐ Meticulous ☐ Unusual ☐

B. Behavior:

WNL ☐ Guarded ☐ Withdrawn ☐ Hostile ☐ Noncompliant ☐ Hyperactive ☐ Suspicious ☐ Cooperative ☐ Unpleasant

C. Cognitions:

☐ WNL ☐ Loose ☐ Scattered ☐ Blocked ☐ Illogical ☐ Delusional ☐ Paranoid ☐ Somatic ☐ Hallucinations ☐ Grandiose ☐ Fragmented

D. Mood/Affect:

☐ WNL ☐ Flat ☐ Depressed ☐ Euphoric

SNAP

Strengths:_____

Needs: _____

Abilities: _____

Preferences:_____

TREATMENT RECOMMENDATIONS

Diagnosis: _____

_____

Level of Care: _____

_____

Parent/Guardian signature: _____ **Date:**_____

Parent/Guardian signature: _____ **Date:**_____

Child signature: _____ **Date:**_____

Therapist signature: _____ **Date:**_____

Interpretive Summary

Therapist signature: _____ **Date:**_____