Child Psychosocial Assessment

Name_____ DOB_____

Mother's Name:_____

Father's Name_____

PRESENTING PROBLEM: What brings you here today?

_____

_____

Mental Health History

Please circle all that apply to you (choose severity that applies):

(0) Not Present, (1) Mild, (2) Moderate, or (3) Severe)

Depression	**0 1 2 3**	Memory Problems	**0 1 2 3**	Panic Attacks	**0 1 2 3**
Anxiety	**0 1 2 3**	Loss of Interest	**0 1 2 3**	Obsessive Thoughts	**0 1 2 3**
Mood Swings	**0 1 2 3**	Irritability	**0 1 2 3**	Ritualistic Behavior	**0 1 2 3**
Appetite Changes	**0 1 2 3**	Excessive Worry	**0 1 2 3**	Checking	**0 1 2 3**
Sleep Changes	**0 1 2 3**	Suicidal Ideation	**0 1 2 3**	Counting	**0 1 2 3**
Hallucinations	**0 1 2 3**	Relationship Issues	**0 1 2 3**	Self-Injury	**0 1 2 3**
Racing Thoughts	**0 1 2 3**	Low Energy	**0 1 2 3**	Difficulty with	**0 1 2 3**
Confusion	**0 1 2 3**	Hyperactivity	**0 1 2 3**	Concentration	

Describe a brief history of your child's present symptoms:

_____

_____

What effect have they had on your child's life?

_____

_____

Has your child ever been treated for a mental health problem? If yes, please describe:

_____

_____

Has your child ever had a mental health hospitalization? ___No ___ Yes, please describe:

_____

Are there any guns in your home? ___ No ____ Yes

Medical History

Previous surgeries/Major Illness/Medical Diagnoses (please include reason and year)

_____

_____

Please list any additional health information that may be important for the therapist to know (including any medication or other allergies or problems with pain):

_____

_____

List daily medications and Dosages (including over the counter medications)

Current Medication	Dosage	Prescribing Physician	Last Dose	Taking as Prescribed?

Is your child having any difficulty with pain? ____No ____ Yes; please describe:

_____

_____

Has your child ever: Binged on food? _____ Gone without eating? _____

Vomited on purpose?_____ Used laxatives to purge? _____

Family History

Describe the family in which your child is being raised:

_____

_____

How does your child get along with members of the family?

_____

_____

Is there a history of mental health or substance abuse problems in your family? ___No ___Yes

If yes, please explain:

_____

_____

Has your child experienced any physical, emotional, or sexual abuse? ____No _____Yes

If yes, please explain:

_____

_____

Educational History:

What school does your child attend, and in what grade?

_____

Did you have any learning or behavioral issues in school? ___ No ____Yes; please explain:

_____

_____

Do you have any educational concerns for your child at this time? ___No ____Yes; please explain:

_____

_____

Developmental History/Behavior Concerns:

Please identify any complications that occurred during pregnancy, delivery, or immediately after the birth of your child:

_____

_____

Please describe the development of your child during early childhood (i.e., normal, delayed, etc.):

_____

_____

Does your child regularly engage in social activities? ____ No ___ Yes

Does your child build positive social relationships? ____ No ___ Yes

Please describe your child's personality:

_____
_____

Do you have any concerns regarding your child's behavior at this time? ____No ____Yes; please explain:

_____
_____

Does your child have any past or current involvement with the legal system? ___No ___Yes; please explain:

_____
_____

Substance Use

To the best of your knowledge, does your child current use any substances (i.e., tobacco, alcohol, marijuana, etc.)? ____No ____Yes

If yes, please provide the name of the substance(s), frequency, and amount of use:

_____
_____
_____

_____

Client Signature **Date**