

**Children and Youth Assessment**  
**Parent/Guardian Form**

Please fill out all of the following pages *prior* to your initial appointment.  
If you do not know the information, please write "Unknown."

Child's name: \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

Child's School Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grades: \_\_\_ Good \_\_\_ Average \_\_\_ Struggles

Pediatrician: \_\_\_\_\_ Last visit to your doctor: \_\_\_\_\_ May we contact them: Yes or No

Mother's Name: \_\_\_\_\_ Her email: \_\_\_\_\_ Phone # \_\_\_\_\_

Father's Name: \_\_\_\_\_ His email: \_\_\_\_\_ Phone # \_\_\_\_\_

**SAFETY CONCERNS:** Are you worried about any of the following for the child?

| No | Yes |   | If yes, please explain |
|----|-----|---|------------------------|
|    |     | Accidentally hurting himself/herself                                  |                        |
|    |     | Suicidal thoughts, threats or attempts                                |                        |
|    |     | Hurting someone else (assaultive behavior to family members of peers) |                        |
|    |     | Other safety concerns:  |                        |

1. The main reason we are here today is:
2. Where do the problems or behaviors usually happen? Home? School? Other?
3. Where do the problems or behaviors NEVER happen?
4. Is there a pattern or trigger for when the problems start? (Time of day? Right before \_\_\_\_? When \_\_\_\_\_ is around? Etc.)
5. What are you most worried might happen?
6. How long have you been worried about this?
7. When did these behaviors begin?
8. What do you think caused the problems?
9. How have you handled problems in the past?
10. What do you think your child is most worried about?
11. When was the last time that your child was doing really well?
12. Please describe the positive behaviors that were happening at the time:

# SYMPTOMS CHECKLIST (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Depressed mood, seems sad  | <input type="checkbox"/> Difficult time sitting still   | <input type="checkbox"/> Fidgets/squirms  |
| <input type="checkbox"/> Irritable  | <input type="checkbox"/> Talks excessively  | <input type="checkbox"/> Often leaves seat  |
| <input type="checkbox"/> Poor appetite  | <input type="checkbox"/> Doesn't listen enough to understand instructions                           | <input type="checkbox"/> Often on the go  |
| <input type="checkbox"/> Sleeps too much  | <input type="checkbox"/> Listens but forgets quickly  | <input type="checkbox"/> Difficulty playing quietly   |
| <input type="checkbox"/> Doesn't sleep enough   | <input type="checkbox"/> Listens & understands but gets distracted easily                           | <input type="checkbox"/> Talks excessively  |
| <input type="checkbox"/> Hopelessness   | <input type="checkbox"/> Hard time listening to boring people                                       | <input type="checkbox"/> Deliberately annoys people   |
| <input type="checkbox"/> Tired more than usual/low energy                                     | <input type="checkbox"/> Often blurts out answers before questions have been completed              | <input type="checkbox"/> Blames others  |
| <input type="checkbox"/> Low self-esteem  | <input type="checkbox"/> Difficulty waiting for his/her turn  | <input type="checkbox"/> Easily annoyed   |
| <input type="checkbox"/> Has lost interest in things that used to be interesting or fun       | <input type="checkbox"/> Often interrupts   | <input type="checkbox"/> Spiteful or vindictive   |
| <input type="checkbox"/> Weight concerns (loss/gain)  | <input type="checkbox"/> Makes careless mistakes  | <input type="checkbox"/> Loses temper   |
| <input type="checkbox"/> Moves slower than normal   | <input type="checkbox"/> Starts out with the intention of finishing but quits in the middle         | <input type="checkbox"/> Argues with adults   |
| <input type="checkbox"/> Has a harder time concentrating than in the past                     | <input type="checkbox"/> Difficult time organizing tasks and activities                             | <input type="checkbox"/> Defies or refuses to comply with requests or rules                             |
| <input type="checkbox"/> Thinks or talks about death  | <input type="checkbox"/> Avoids participating in things that require sitting still or concentrating | <input type="checkbox"/> Self-mutilation or harm  |
| <input type="checkbox"/> Suicidal thoughts or behaviors                                       | <input type="checkbox"/> Often loses things   | <input type="checkbox"/> Abnormalities in speech  |
| <input type="checkbox"/> Elevated stress, anxiety, and worry seem to be new behaviors         | <input type="checkbox"/> Easily distracted  | <input type="checkbox"/> Excessive reaction to change or routine  |
| <input type="checkbox"/> Worries a lot  | <input type="checkbox"/> Forgetful in daily activities  | <input type="checkbox"/> Initiates or terminates interaction inappropriately                            |
| <input type="checkbox"/> Very anxious and nervous most of the time                            | <input type="checkbox"/> Child is having difficulty in relationships with peers                     | <input type="checkbox"/> Significantly indiscreet marks   |
| <input type="checkbox"/> Nervous or worried about things more than other kids                 | <input type="checkbox"/> Family relationships are suffering because of attitude                     | <input type="checkbox"/> Little or no interest in peers or family                                       |
| <input type="checkbox"/> There is a clear reason for worries and stress                       | <input type="checkbox"/> Family relationships are suffering because of behaviors                    | <input type="checkbox"/> Explosive temper with minimal provocation                                      |
| <input type="checkbox"/> More oppositional than usual   | <input type="checkbox"/> Deliberately annoys people   | <input type="checkbox"/> Stereotyped mannerisms or posture  |
| <input type="checkbox"/> Recent head injury   | <input type="checkbox"/> Often angry and resentful  | <input type="checkbox"/> Overreaction to touch or noise   |
| <input type="checkbox"/> Feels sick without a clear reason                                    | <input type="checkbox"/> Wants revenge  | <input type="checkbox"/> Compulsive rituals   |
| <input type="checkbox"/> Unrealistic worry about the future                                   | <input type="checkbox"/> Loses temper   | <input type="checkbox"/> Motor or vocal tics  |
| <input type="checkbox"/> Unrealistic concern about past events                                | <input type="checkbox"/> Thinking that all rules are stupid   | <input type="checkbox"/> Drug and alcohol use resulting in failure in work, school, or home obligations |
| <input type="checkbox"/> Feels self-conscious   | <input type="checkbox"/> Argues with adults   | <input type="checkbox"/> Drug and alcohol use resulting in physically dangerous situations              |
| <input type="checkbox"/> Excessive distress when thinking about being away from parent        | <input type="checkbox"/> Defies or refuses to comply with requests or rules                         | <input type="checkbox"/> Legal problems   |
| <input type="checkbox"/> Distress when away from home   | <input type="checkbox"/> Explosive temper with minimal provocation                                  | <input type="checkbox"/> Social or interpersonal problems   |
| <input type="checkbox"/> Worries about bad things happening to parent or family               | <input type="checkbox"/> Aggression toward people/animals   | <input type="checkbox"/> Drug and alcohol use resulting in tolerance/withdrawal                         |
| <input type="checkbox"/> Persistent school refusal because of being away from home or parents | <input type="checkbox"/> Hurts animals on purpose   | <input type="checkbox"/> Intoxication (drunk)   |
| <input type="checkbox"/> Avoids being alone   | <input type="checkbox"/> Destroys property when angry or as revenge                                 |   |
| <input type="checkbox"/> Refuses to sleep alone   | <input type="checkbox"/> Lies to get out of consequences  |   |
|   | <input type="checkbox"/> Lies to look good  |   |
|   | <input type="checkbox"/> Lies for no good reason  |   |
|   | <input type="checkbox"/> Breaks the law   |   |
|   | <input type="checkbox"/> Blames others for problems   |   |
|   | <input type="checkbox"/> Does not seem to understand the feelings of others/lacks empathy           |   |

## PAST TREATMENT

1. Has your child ever been to see a counselor/therapist before?

\_\_\_ No \_\_\_ Yes

Please explain: (When? Who did you see? Was it helpful? What worked, what didn't work?)

2. Is your child getting treatment from anyone else right now?

\_\_\_ No \_\_\_ Yes

Please explain:

3. Has your child received a mental health diagnosis from any other counselor/therapist or doctor?

\_\_\_ No \_\_\_ Yes

If yes, what were the diagnoses? Did you agree with them?

## MEDICATIONS

| Medication(s) | Taking now | Tried in the past | Dose | Frequency | Duration?<br>Started-<br>ended | Doctor |
|---------------|------------|-------------------|------|-----------|--------------------------------|--------|
|---------------|------------|-------------------|------|-----------|--------------------------------|--------|

## FAMILY RELATIONSHIPS

| Relationship with child     | Close | Average | Distant | None | What does your child enjoy about this relationship? | Problems or conflicts in the relationship are about? |
|-----------------------------|-------|---------|---------|------|---|--|
| Mother                      |       |         |         |      |   |  |
| Father                      |       |         |         |      |   |  |
| Sibling: Name/age           |       |         |         |      |   |  |
| Sibling: Name/age           |       |         |         |      |   |  |
| Sibling: Name/age           |       |         |         |      |   |  |
| Sibling: Name/age           |       |         |         |      |   |  |
| Step-parent Name:           |       |         |         |      |   |  |
| Step-parent Name:           |       |         |         |      |   |  |
| Mom's boyfriend or partner  |       |         |         |      |   |  |
| Dad's girlfriend or partner |       |         |         |      |   |  |
| Other:                      |       |         |         |      |   |  |





**ADAPTIVE BEHAVIOR:**

Do you have major conflicts around bed time?  Yes  No  
 Does your child sleep in their own bed?  Yes  No  
 Average length of time to settle down for bed? \_\_\_\_\_ Minutes  
 Does the child sleep through the night?  Yes  No  
     Night terrors?  Yes  No      how often?  
     Nightmares?  Yes  No      how often?  
 Does the child sit through meals?  Yes  No  
 Appetite:  good  fair  poor  picky  
 Is there usually parent-child conflict around dressing?  Yes  No  
 Can child play independently?  Yes  No      Average length of time: \_\_\_\_\_ minutes  
 Is your child's play imaginative?  Yes  No  
 Describe your child's favorite activities:

Can your child follow a      1-part instruction?  Yes  No  
   2-part instruction?  Yes  No  
   3-part instruction?  Yes  No

**EXPRESSION OF FEELINGS:**

Are you usually able to accurately interpret how your child is feeling?  Yes  No  
 During the day, what is your child's most typical feeling state?  
 Happy  Angry  Frustrated  Sad  Anxious/Worried  
 When hurt, does your child seek comfort?  Yes  No  
     Accept comfort?  Yes  No  
     Refused comfort?  Yes  No  
     Can comfort self?  Yes  No  
     No reaction?  Yes  No  
     Not sure?  Yes  No

**FEARS:**

|                          |         |                          |               |                          |               |                          |                   |
|--------------------------|---------|--------------------------|---------------|--------------------------|---------------|--------------------------|-------------------|
| <input type="checkbox"/> | None    | <input type="checkbox"/> | Public places | <input type="checkbox"/> | Closed spaces | <input type="checkbox"/> | Heights           |
| <input type="checkbox"/> | Animals | <input type="checkbox"/> | Flying        | <input type="checkbox"/> | Insects       | <input type="checkbox"/> | Social activities |
| <input type="checkbox"/> | Travel  | <input type="checkbox"/> | Schools       | <input type="checkbox"/> | Germs         | <input type="checkbox"/> | Other:            |
| Describe:                |         |                          |               |                          |               |                          |                   |

**RITUALS:**

|                          |          |                          |              |                          |          |                          |          |
|--------------------------|----------|--------------------------|--------------|--------------------------|----------|--------------------------|----------|
| <input type="checkbox"/> | None     | <input type="checkbox"/> | Hand washing | <input type="checkbox"/> | Counting | <input type="checkbox"/> | Checking |
| <input type="checkbox"/> | Touching | <input type="checkbox"/> | Other:       | <input type="checkbox"/> |          | <input type="checkbox"/> |          |
| Describe:                |          |                          |              |                          |          |                          |          |

**OBESSIONS (excessive worry):**

|                          |                             |                          |                   |                          |          |                          |               |
|--------------------------|-----------------------------|--------------------------|-------------------|--------------------------|----------|--------------------------|---------------|
| <input type="checkbox"/> | None                        | <input type="checkbox"/> | Illness & disease | <input type="checkbox"/> | Death    | <input type="checkbox"/> | Contamination |
| <input type="checkbox"/> | Harm to parents or siblings | <input type="checkbox"/> | Disasters         | <input type="checkbox"/> | Violence | <input type="checkbox"/> | Other:        |
| Describe:                |                             |                          |                   |                          |          |                          |               |



Has your child ever witnessed domestic violence?  Yes  No  
 Has anyone in the family been a victim of a violent crime?  Yes  No  
 Has the child ever been physically abused?  Yes  No  
 Has the child ever been sexually abused?  Yes  No  
 Has the child ever been neglected?  Yes  No  
 Are there any other agencies currently providing services?  Yes  No

|      |                            |                           |
|------|----------------------------|---------------------------|
| DCFS | Local Mental Health Center | Local Interagency Council |
| DWS  | Other Mental Health Center | Family or Youth Advocate  |
| DHS  | Local School District      | Youth Corrections         |

Is a parent incarcerated currently?  Yes  No

|        |        |             |
|--------|--------|-------------|
| Mother | Father | Step-parent |
|--------|--------|-------------|

Has either parent ever been incarcerated?  Yes  No

|        |        |             |
|--------|--------|-------------|
| Mother | Father | Step-parent |
|--------|--------|-------------|

If yes, does the child visit?  Yes  No How often?

### LEGAL INVOLVEMENT OF CHILD

Has either parent ever been incarcerated?  Yes  No

Probation officer's name:

|                       |                     |                           |
|-----------------------|---------------------|---------------------------|
| None                  |                     |                           |
| Breaking and entering | Public intoxication | Assault                   |
| Arrests               | Charge file         | Burglary                  |
| Possession of weapon  | Petty theft         | Illegal use of automobile |
| Drug sales            | DUI                 | Drug possession           |

### CULTURAL/ETHNIC/RACIAL ISSUES

Are you aware of any cultural, ethnic, or racial issues with your child?  Yes  No

Is your family or child/youth experiencing problems with:

Stigma  Prejudice  Insensitivity  Preference in provider  
 Language  Stereotyping  Racism  Other

How has your child handled this?

Is your child accepted by peers?  Yes  No

Is your child able to share his/her culture with others?  Yes  No

Please describe:

### SPIRITUAL RELIGIOUS ISSUES

Are you aware of any religious or spiritual issues with your child?  Yes  No

Does your family or child/youth experience problems with:

Inability to participate in preferred religion  
 Insensitivity from others  
 Insensitivity toward others  
 Difficulty being accepted by peers due to religion or spiritual preference

How have you handled this?

Do you and your child have important differences in spiritual or religious beliefs or practices?

Yes  No

If yes, is this causing significant relationship problems at home?  Yes  No

Does your child practice an organized religion?  Yes  No Religion: \_\_\_\_\_



**Is there anything else that you feel your therapist should know?**

**What STRENGTHS, SKILLS, ATTRIBUTES, PERSONALITY TRAITS etc. does your child have RIGHT NOW that will help them in life? (What do you like most about them? BRAG!)**

**Treatment goal(s):**

**What can we help you and your family accomplish in the next 3-6 months?**

*Please be as specific as possible.*

**Discharge goal(s):**

**Please describe your ideal vision of how life will be when there are some positive changes?**

*For instance: My child will \_\_\_\_\_ when \_\_\_\_\_. or My family will be able to \_\_\_\_\_.*

**Congratulations for finishing this form and thank you for providing all of this information. It will be very helpful in working together to figure out how to best provide treatment to you and your family. Today's appointment will probably last about an hour.**