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."

Childs 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)

- [ ] Depressed mood, seems sad
- [ ] Irritable
- [ ] Poor appetite
- [ ] Sleeps too much
- [ ] Doesn’t sleep enough
- [ ] Hopelessness
- [ ] Tired more than usual/low energy
- [ ] Low self-esteem
- [ ] Has lost interest in things that used to be interesting or fun
- [ ] Weight concerns (loss/gain)
- [ ] Moves slower than normal
- [ ] Has a harder time concentrating than in the past
- [ ] Thinks or talks about death
- [ ] Suicidal thoughts or behaviors

- [ ] Elevated stress, anxiety, and worry seem to be new behaviors
- [ ] Worries a lot
- [ ] Very anxious and nervous most of the time
- [ ] Nervous or worried about things more than other kids
- [ ] There is a clear reason for worries and stress

- [ ] More oppositional than usual
- [ ] Recent head injury
- [ ] Feels sick without a clear reason
- [ ] Unrealistic worry about the future
- [ ] Unrealistic concern about past events
- [ ] Feels self-conscious
- [ ] Excessive distress when thinking about being away from parent
- [ ] Distress when away from home
- [ ] Worries about bad things happening to parent or family
- [ ] Persistent school refusal because of being away from home or parents
- [ ] Avoids being alone
- [ ] Refuses to sleep alone

- [ ] Difficult time sitting still
- [ ] Talks excessively
- [ ] Doesn’t listen enough to understand instructions
- [ ] Listens but forgets quickly
- [ ] Listens & understands but gets distracted easily
- [ ] Hard time listening to boring people
- [ ] Often blurts out answers before questions have been completed
- [ ] Difficulty waiting for his/her turn
- [ ] Often interrupts
- [ ] Makes careless mistakes
- [ ] Starts out with the intention of finishing but quits in the middle
- [ ] Difficult time organizing tasks and activities
- [ ] Avoids participating in things that require sitting still or concentrating
- [ ] Often loses things
- [ ] Easily distracted
- [ ] Forgetful in daily activities
- [ ] Child is having difficulty in relationships with peers
- [ ] Family relationships are suffering because of attitude
- [ ] Family relationships are suffering because of behaviors
- [ ] Deliberately annoys people
- [ ] Often angry and resentful
- [ ] Wants revenge
- [ ] Loses temper
- [ ] Thinking that all rules are stupid
- [ ] Argues with adults
- [ ] Defies or refuses to comply with requests or rules
- [ ] Explosive temper with minimal provocation

- [ ] Aggression toward people/animals
- [ ] Hurts animals on purpose
- [ ] Destroys property when angry or as revenge
- [ ] Lies to get out of consequences
- [ ] Lies to look good
- [ ] Lies for no good reason
- [ ] Breaks the law
- [ ] Blames others for problems
- [ ] Does not seem to understand the feelings of others/lacks empathy

- [ ] Fidgets/squirms
- [ ] Often leaves seat
- [ ] Often on the go
- [ ] Difficulty playing quietly
- [ ] Talks excessively

- [ ] Deliberately annoys people
- [ ] Blames others
- [ ] Easily annoyed
- [ ] Spiteful or vindictive
- [ ] Loses temper
- [ ] Argues with adults
- [ ] Defies or refuses to comply with requests or rules

- [ ] Self-mutilation or harm
- [ ] Abnormalities in speech
- [ ] Excessive reaction to change or routine
- [ ] Initiates or terminates interaction inappropriately
- [ ] Significantly indiscreet marks
- [ ] Little or no interest in peers or family
- [ ] Explosive temper with minimal provocation
- [ ] Stereotyped mannerisms or posture
- [ ] Overreaction to touch or noise
- [ ] Compulsive rituals
- [ ] Motor or vocal ties
- [ ] Drug and alcohol use resulting in failure in work, school, or home obligations
- [ ] Drug and alcohol use resulting in physically dangerous situations
- [ ] Legal problems
- [ ] Social or interpersonal problems
- [ ] Drug and alcohol use resulting in tolerance/withdrawal
- [ ] Intoxication (drunk)

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? Started-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:						

FAMILY HISTORY (check all that apply)

	None/NA/ Unknown	Past problem drugs or alcohol	Current drugs	Current alcohol	Depression	Suicide attempt	Anxiety/ Panic	Schizophrenia	Bipolar	Bizzare behavior	ADHD history	Abuse history
Father												
Mother												
Step-father												
Step-mother												
Sibling												
Sibling												
Sibling												
Sibling												
Paternal Grandpa												
Paternal Grandma												
Maternal Grandpa												
Maternal Grandma												

PEER RELATIONSHIPS

1. Who are the important adults in your child's life?

2. Who are the important friends in your child's life?

3. How easily does your child make friends?

1☐ Easier than average 2☐ average 3☐ worse than average

4. Do friends come to your home?

1☐ Frequently 2☐ Occasionally 3☐ Seldom 4☐ None

5. What roles does your child take when playing with peers?

☐ Passive ☐ Assertive ☐ Aggressive ☐ Follower
☐ Leader ☐ Bossy ☐ Controlling ☐ Other ________________

DISCIPLINE

Most frequent used form of discipline:

☐ Time out ☐ Grounding
☐ Extra Chores ☐ Loss of objects or privileges ☐ Spanking
Other (describe) ____

Does discipline work? ☐ Yes ☐ No
How many people are responsible for disciplining your child? ____
Do caretakers agree about type of discipline? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Pregnancy was ☐ Planned ☐ Unplanned

Reaction to pregnancy by mother: ☐ positive ☐ neutral ☐ negative

Reaction to pregnancy by father: ☐ positive ☐ neutral ☐ negative

What medications, if any, were used by mother during pregnancy?

Use of drugs/alcohol/tobacco by mother prior to, during, or after pregnancy

☐ Yes ☐ No If yes, describe:

Use of drugs/alcohol/tobacco by father prior to, during, or after pregnancy

☐ Yes ☐ No If yes, describe:

Emotional stress prior to, during, or after pregnancy?

☐ Yes ☐ No If yes, describe:

Depression prior to, during, or after pregnancy?

☐ Yes ☐ No If yes, describe:

Birth weight of child: _____ lbs. _____ oz.

Did parents have difficulty establishing a sleep routine/schedule? ☐ Yes ☐ No

Child was cared for by: ☐ parent ☐ relative ☐ sitter ☐ daycare ☐ other

Infant was usually: (Check all that apply)

☐ Easy to feed	☐ Difficult to feed	☐ Often fussy or irritable	☐ Easy going
☐ Happy and content	☐ Played peek-a-boo	☐ Good sleeper	☐ Difficulty sleeping
☐ Cried a lot	☐ Colic	☐ Sad	

Developmental Milestones

Sitting up	☐ early	☐ average (5-8 months)	☐ late
Crawling	☐ early	☐ average (7-10 months)	☐ late
Walking	☐ early	☐ average (12-14 months)	☐ late
Single words	☐ early	☐ average (12-18 months)	☐ late
2 word sentences	☐ early	☐ average (16-20 months)	☐ late
Toilet training	☐ early	☐ average (24 months)	☐ late

Are there any concerns or problems with the following?

☐ wetting ☐ soiling ☐ withholding ☐ smearing ☐ other: ______________

CHILDHOOD ISSUES:

Behavior with others (friends, family) after warming up?

1☐	2☐	3☐
more sociable	average	more unsociable

When child wants something, how insistent is he/she?

1☐	2☐	3☐	4☐	5☐
very insistent	pretty insistent	average	not very insistent	not at all insistent

How easily does your child handle change?

1☐	2☐	3☐
easily	average	resistant

Activity level as a child

1☐	2☐	3☐	4☐	5☐
very active	active	average	less active	not active

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:____ mintues

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:

☐	None	☐	Public places	☐	Closed spaces	☐	Heights
☐	Animals	☐	Flying	☐	Insects	☐	Social activities
☐	Travel	☐	Schools	☐	Germs	☐	Other:
Describe:							

RITUALS:

☐	None	☐	Hand washing	☐	Counting	☐	Checking
☐	Touching	☐	Other:				
Describe:							

OBESSIONS (excessive worry):

☐	None	☐	Ilness & disease	☐	Death	☐	Contamination
☐	Harm to parents or siblings	☐	Disasters	☐	Violence	☐	Other:
Describe:							

CHILD'S MEDICAL HISTORY

Are there any medical problems related to your child's mental health problems? ☐ Yes ☐ No

Have you seen your family doctor about your concerns? ☐ Yes ☐ No

General health: 1☐ very good 2☐ good 3☐ fair 4☐ poor 5☐ very poor

Does your child/youth have any allergies?

Hearing loss?

Speech or language problems?

Any surgery or hospitalizations?

Chronic health problems:

Asthma	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Liver Problems	☐ Yes ☐ No
Heart Condition	☐ Yes ☐ No	Chronic Pain	☐ Yes ☐ No
Seizure Disorder	☐ Yes ☐ No	Neurological Problems	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No	Other:	☐ Yes ☐ No
Failure to Thrive	☐ Yes ☐ No	Other:	☐ Yes ☐ No

SCHOOL & DAYCARE HISTORY

Is your child in school? ☐ Yes ☐ No

What is the number of schools/daycares attended: ___________

Has your child been suspended from school/daycare? ☐ Yes ☐ No

If yes, please explain:

Has your child ever been in any type of special education program? ☐ Yes ☐ No

If yes, please explain:

Is your child's school concerned about your child? ☐ Yes ☐ No

If yes, please explain:

STRESSORS

Are any of these situations in your child's life?	Yes or No	If yes, please explain
Move to a new home		How many? _____
Parent(s) remarried/new parent		
Divorce/Separation		
Employment changes		
Birth of sibling		
Change of school or daycare		
Death in family		
Financial stress		
Serious illness in family members		
Foster care		
Homeless		
Adoption		
Substance use/abuse by the child?		
Substance use/abuse by family member?		
Other:		

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
☐	Posession 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.