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Child and Family Therapy Center PC

PARENT PSYCHOLOGICAL ASSESSMENT FORM (CHILD/ADOLESCENT)

This questionnaire will help us get to know a little more about your child/adolescent, including both past and present history.

PERSONAL INFORMATION:

Child/Adolescent's Name: _____ Date: _____
Date of Birth: _____ Age: _____
Gender Identity: □ Male □ Female □ Transgender □ Other: _____
Race/Ethnicity: _____
Religious Preference/Affiliation: _____
Primary Language(s) Spoken at Home: _____
Child/Adolescent's School Name: _____
Child/Adolescent's Grade: _____

Child/Adolescent's Physical Address: _____
Person Completing Intake Form: _____
Relationship to Child/Adolescent: _____

Parent/Caregiver 1 Name: _____
Relationship to Child/Adolescent: _____
Physical Address: _____
Best Contact Phone Number: _____

Parent/Caregiver 2 Name: _____
Relationship to Child/Adolescent: _____
Physical Address: _____
Best Contact Phone Number: _____

Biological Parent(s) Name(s) – If Different from Above: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION:

Please list all the individuals whom currently live with your child/adolescent, including caregivers. Please also indicate if separate households.

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Name	Age	Relationship	Occupation/Grade

PSYCHOLOGICAL TESTING HISTORY:

Has your child/adolescent ever had past cognitive or psychological testing (e.g. psychoeducational testing, IEP's)? □ Yes □ No □ Unsure
Do you have these records to provide? □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____
_____

What specific questions would you like to be answered by the psychological evaluation?
_____
_____
_____

SAFETY/RISK CONCERNS:

Has your child/adolescent ever purposely harmed himself/herself (e.g. cut, burned, bruised their body, or other)?
□ Yes □ No
If yes, please provide additional details. _____
_____
_____

Has your child/adolescent ever attempted suicide? □ Yes □ No
If yes, please provide additional details. _____
_____
_____
_____

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Has your child/adolescent ever been evaluated for danger to self, danger to others, or grave disability (5150 evaluation)? □ Yes □ No □ Unsure
If yes or unsure, please provide additional details (e.g. date(s) of evaluation(s), location, person whom completed evaluation).

_____
_____
_____

Has your child/adolescent ever been psychiatrically hospitalized for danger to self, danger to others, or grave disability (5150 Hold)? □ Yes □ No □ Unsure
If yes or unsure, please provide additional details (such as date(s) of hospitalization, reason for hospitalization, inpatient facility where they resided during this stay/multiple stays).

_____
_____
_____

Has your child/adolescent ever expressed thoughts of harming or killing others? □ Yes □ No
If yes, please provide additional details. _____
_____
_____

Has your child/adolescent ever reported to you that they hear voices or see things that are not there?
□ Yes □ No
If yes, please provide additional details. _____
_____
_____

DEVELOPMENTAL AND MEDICAL HISTORY:

Were there any problems or complications during your pregnancy, labor, or delivery?
□ Yes □ No
If yes, please explain. _____

Was there any in utero exposure to alcohol, drugs, tobacco during pregnancy? □ Yes □ No
If yes, please explain. _____

Were there any accidents or major illnesses experienced during pregnancy? □ Yes □ No
If yes, please explain. _____
_____

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Did your child/adolescent have any health problems at birth? □ Yes □ No
If yes, please explain. _____
_____

Did your child/adolescent experience any developmental delays (e.g. talking, walking, toilet training)?
□ Yes □ No
If yes, please explain. _____
_____

What was your child/adolescent's behavior as an infant/baby? (Please check all that apply)

- □ Ate Well
- □ Easy to Soothe
- □ Easy to Regulate
- □ Adaptable to Transitions
- □ Colicky
- □ Clumsy
- □ Head Banging
- □ Dare-devil behavior
- □ Wanted to be left alone
- □ Other:

Has your child/adolescent experienced any medical problems in past or present? (Please check all that apply)

- □ Allergies
- □ Asthma
- □ Operations
- □ Head injuries/concussion
- □ Poisoning
- □ Serious Infection
- □ Convulsions
- □ Bladder/bowel problems
- □ Ear Infections
- □ Other:

Has your child/adolescent ever been diagnosed with a psychological disorder (e.g. depression, anxiety, ADHD, etc.)? □ Yes □ No □ Unsure
If yes or unsure, please provide additional details (e.g. name of provider, date). _____
_____
_____

Has your child/adolescent ever taken medication for a mental health reason?
□ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____
_____

Does your child/adolescent take any medication (including for psychiatric reasons), vitamins, supplements, or herbal remedies?
□ Yes □ No If yes, please indicate what type and dosage. _____
_____
_____

Did your child/adolescent take their prescribed medication today? □ Yes □ No □ Unsure
Please explain. _____
_____

What is the name of the physician or psychiatrist who is managing your child/adolescent's medications?
_____

Physician's/Psychiatrist's address: _____

PSYCHOSOCIAL HISTORY:

Family Events/Stressors
Is your family experiencing any of the following challenges at present? Or in the past?
(Please check any that apply and indicate if past and/or present)

	Present	Past		Present	Past		Present	Past
Marital Problems	☐	☐	Custody Disputes	☐	☐	Financial Problems	☐	☐
Divorce/ Separation	☐	☐	Blended Family	☐	☐	Housing Problems	☐	☐
Death of Loved One	☐	☐	Serious Family Illness	☐	☐	Parent Alcohol/Drug Use	☐	☐
Parent Job Loss	☐	☐	Trauma	☐	☐	Other:	☐	☐

Has your child/adolescent experienced any of the following in the past and/or present?

Psychological abuse (e.g. they were harshly yelled at, repeatedly "put down," victim of controlling behavior). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Physical abuse (e.g. they were hit, kicked, beaten up, or threatened to be hit).
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____
_____

Sexual abuse (e.g. inappropriately touched, molested, assaulted). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Neglect (e.g. left unattended for extended periods of time, lacked clothing, food, were left soiled/dirty, failed to be provided needed medical/dental care or treatment).
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____
_____

Witnessed violence at home (e.g. frequent verbal fighting, physical fighting, or sexual abuse among parents). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Interpersonal/dating violence. □ Yes □ No □ Unsure
If yes or unsure, please explain. _____

Bullying, cyber-bullying by peers and/or classmates, or victim of peer violence.
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____
_____

Are there any firearms in your home? □ Yes □ No
If yes, how are they secured? Does your child have access? Please explain.
_____
_____

Family and Social Relationships

How does your child/adolescent behave or interact with their siblings?
□ Poor □ Average □ Good □ Does not apply

How does your child/adolescent behave or interact with you, their parent, guardian, or caregiver?
□ Poor □ Average □ Good □ Unsure

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What are your child/adolescent's social skills with peers?
□ Poor □ Average □ Good □ Unsure

Parental Discipline

What discipline strategies do you use with your child/adolescent? (Please select any that apply)
□ Removal of Privileges □ Rewards/Incentives □ Verbal reprimands/Discussions
□ Physical Punishment □ Grounding

How helpful are your current discipline strategies?
□ Helpful most of the time □ Unhelpful most of the time

Health Habits

How often does your child/adolescent exercise per day (average)?
□ 0 □ 30 minutes □ 1-2 hours □ 3 or more hours

What is your child/adolescent's media, social media, and/or video gaming use per day (average # of hours)?
□ 0 □ 1-2 hours □ 3-4 hours □ 5 or more hours

Do you have any concerns with your child/adolescent's media, social media, and video gaming use?
□ Yes □ No If yes, please explain. _____
_____

How much caffeine does your child/adolescent consume per day (e.g. coffee, soda, energy drinks)?
□ 0 drinks □ 1-2 drinks □ 3-4 drinks □ 5 or more drinks

How many hours does your child/adolescent sleep per night?
□ 5 hours or less □ 6-7 hours □ 8-10 hours □ 11-12 hours

Has your child/adolescent ever been involved with the juvenile justice system?
□ Yes □ No If yes, please explain. _____
_____

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Has your child/adolescent ever experimented with or used substances in past or present?
□ Yes □ No If yes, please provide additional information (e.g. if past/present, type of substance(s) consumed – alcohol, tobacco, marijuana, other drugs and any other pertinent details). _____
_____
_____

If yes, do you have concerns with your child/adolescent's current substance use?
□ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Educational History

How would you describe your child/adolescent's current school performance?
□ Poor □ Average □ Above Average

How would you describe your child/adolescent's current attitude toward school?
□ Poor □ Average □ Above Average

Does your child/adolescent attend school regularly? □ Yes □ No □ Unsure
If no or unsure, please explain. _____

Does your child/adolescent receive/participate in any of the following academic services? (Please check all that apply)

- □ Home Hospital Program
- □ Independent Study
- □ Gifted Program (GATE)
- □ Resource Classes/Special Education
- □ Speech Therapy
- □ Occupational Therapy
- □ 504 Plan/Accommodations
- □ Individualized Education Plan (IEP)
- □ Other:

Does your child/adolescent have any school problems? (Please check all that apply)

- □ Learning Problems
- □ Works hard, but does not do well
- □ Repeated grade(s) (Grade(s): _____)
- □ Frequent discipline referrals (#_____)
- □ Problems with Teachers
- □ Suspensions/Expulsions (#_____)
- □ Other school problems:

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Family Psychiatric History

Do any of your child or adolescent's biological family members have any history of psychiatric, emotional, and/or substance use problems? (Please specify which family members and indicate if family members have experienced these conditions in past or present).

		Relationship to Child/Adolescent
Developmental delays or Autism Spectrum Disorders	☐	
Child inattention, hyperactivity, or poor impulse control	☐	
Learning Disabilities	☐	
Depression (2 weeks or more)	☐	
Anxiety, Phobias, Panic Attacks, or OCD	☐	
Mood swings or Bipolar Disorder	☐	
Eating Disorders/Disordered Eating Practices	☐	
Suicide attempts or completion	☐	
Tics/Tourette's Disorder	☐	
Schizophrenia or psychosis	☐	
Alcohol or Drug Use/Abuse	☐	
Antisocial behavior (assaults to family and others, thefts, arrests)	☐	

OTHER INFORMATION:

Is there anything else that you would like us to know about your child/adolescent?

_____

_____

_____