Counseling and Trauma Services LLC
Initial Assessment, Child

Child's name_____Birth Day _____

Mother's name_____

Father's name_____

Address: _____

Phone Numbers: Home (M)_____(F)_____

Cell (M)_____(F)_____

Parent's work number (M) _____

(F)_____

Please * star *which phone number you would like us to use first.

Parents are: Married Divorced Separated Single

If parents are not together, who has the primary custody of the child?

_____

Family Dynamics: mark or circle the correct answer
_____lives with both birth parents.
_____lives with one birth parent Circle which one M F
_____lives with Adoptive Foster Other

Emergency Contact:_____
Relationship:_____

Is Children and Youth services involved with your child in any way? Please explain:

_____

Are there any legal or custody issues currently going on? Yes No,
if so, please explain.

_____
_____
_____

Names and relationship of others who live in the family._____
_____
_____
_____

Family doctor Information:

Name_____

Address:_____

Phone Number: _____

Past or current medical problems and any hospitalizations your child has had: _____

Past psychiatric problems, including hospitalizations

Current Medications

Have you or your family ever suspected or been diagnosed with a mental health disorder Yes___ No__

If so, who was it and name the suspected disorder _____
:_____

Has your child ever thought about hurting himself/herself?

Is the child participating in self-injurious behaviors like cutting?
_____N/A _____past _____present

Has anyone else in your family ever thought about or tried to hurt or kill themselves? Yes___ No___

If so, who was it, when did it happen and what was the method?_____

_____

Has your child ever experienced mental health problems where he / she felt physically or mentally

threatened or afraid?

Exposure to natural or man made disasters Yes___ No___
Emotional Abuse Yes___ No ___
Physical Abuse Yes___ No___
Sexual Abuse Yes___ No ___
Domestic violence Yes___ No___
War Yes___ No ___
Other occurrences Yes___No___
Abuse or neglect issues (including sexual abuse/neglect, perpetrator issues)

_____
_____
_____

Has your child ever used drugs or alcohol? Yes ___ No ___

If so, what drugs, amount, and date of last use.

_____
_____
_____

Does anyone in the family have a history of drug or alcohol problems?

_____

Pregnancy _____planned _____unplanned
_____normal _____complications
_____premature _____unknown

Delivery _____natural _____prepared
_____unprepared _____difficult _____uneventful

Labor was: _____hours
Birth Weight _____lbs. _____Apgar Score

Birth Defects:_____

Family stressors during pregnancy_____
_____

Exposure to toxins: _____drugs _____alcohol
_____disease _____none

Insults: _____prenatal _____perinatal _____postnatal

Developmental: Post-natal Difficulties
_____eating _____weight gain _____sleeping
_____daily routine _____none

Milestones: Timing/Delay in Developmental

_____crawling _____walking _____toilet training
_____speech and language _____other
Explain_____

Why does your child need counseling?_____
_____
_____

Childhood History
_____
_____
_____
_____

Family and Social History
_____
_____
_____

Interpersonal Relationships
_____
_____
_____

Spirituality / Religious Perspective

Cultural Perspective

Leisure / Recreational / Interests
_____
_____

Child's strengths, Interests and Activities
_____
_____

Problems

Parent /Child Conflict	_____N/A	_____past	_____present
Sibling Conflict	_____N/A	_____past	_____present
Peer Problems	_____N/A	_____past	_____present
Attention Seeking	_____N/A	_____past	_____present
Temper Tantrums	_____N/A	_____past	_____present
Nightmares	_____N/A	_____past	_____present
Cheating	_____N/A	_____past	_____present
Lying	_____N/A	_____past	_____present
Assaultive Behavior	_____N/A	_____past	_____present
Cruelty to Animals	_____N/A	_____past	_____present
Fire Setting	_____N/A	_____past	_____present
Runaway	_____N/A	_____past	_____present
Stealing/Shoplifting	_____N/A	_____past	_____present

Comments about any of the above problems:
:_____
_____

Is the child involved with gang activities or knows someone who is in a gang?
_____N/A _____past _____present

Is the child involved with satanic cults/rituals or knows someone who is?
_____N/A _____past _____present

Name of Child's School_____
Grade:_____
School
Activities_____
_____
_____
_____

How is the child's grades? _____Excellent _____Average
_____Just Passing _____Failing
Has there been a change in school behaviors or grades? Yes___ No___
_____
_____

Is the child in a special
classes?_____
_____
_____

Does the child have an IEP? _____Yes _____No
Reason_____

Problems in School

School Refusal	_____yes	_____no
Bullying Others	_____yes	_____no
Being Bullied	_____yes	_____no
Discipline Problems	_____yes	_____no
Homework Problems	_____yes	_____no
Hyperactivity _	_____yes	_____no
Poor Attention Span	_____yes	_____no
Does the child have friends?	_____yes	_____no
Frequent visits to the School Nurse?	_____yes	_____no

Is there any other problems in school with your
child?_____
_____
_____