

Counseling Center for Emotional Growth

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Child and Adolescent Initial Assessment

Client Name: _____ Date: _____ Age: _____

Birthday: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Leave a Message? Yes No

Cell Phone: _____ Leave a Message? Yes No

E-mail: _____

Who has current custody/guardianship of child? Mother Father Both Parents

Relative _____ Other _____

Parent/Legal Guardian Information

Name(s) _____

Address (if different): _____

Home Phone: _____ Leave a Message? Yes No

Cell Phone: _____ Leave a Message? Yes No

E-mail: _____

Birthday: _____ Age: _____ Occupation: _____

Employer: _____

Address: _____

Work Phone: _____ Leave a Message? Yes No

Referred By: _____

Where would you like us to leave reminder messages: Home _____ Work _____ Cell Phone _____

In the event of an emergency with client/child, whom should we contact?

Name: _____ Relationship: _____ Ph. # _____

Insurance Information

Primary Insurance _____

Employer _____

Primary Subscriber Date of Birth _____

SS# _____

Policy # _____ Group # _____

Insurance Telephone Number _____

Authorization Required (Y/N) _____

Primary Subscriber _____

I authorize payment of any insurance benefits to the provider of services (Counseling Center for Emotional Growth)

Client Signature _____

Date _____

Child's Symptoms and Behaviors

Presenting Problem(s): Please state your concerns; specify nature of problem, duration, frequency, and severity: _____

What are the most important issues you would like your child or teen to work on in therapy?

Does your child have behavior problems in the community (e.g. on probation, truancy, legal problems)?

- Does your child have any past/current substance use/abuse? cigarettes drugs alcohol
- drugs and alcohol
- denies use remission 90+ days
- none

If yes, please describe substances used, amount, and effect on child's performance at home and school:

Describe any abuse of substances that runs in the family:

Please indicate how the following symptoms/problems/complaints are affecting your child/teen. Place the appropriate number in each box that applies (Leave blank if no effect):

1) Little affect

2) Some affect

3) Much affect

4) Significant affect

Isolates/ Withdraws	Generalized Anxiety	Weight Change
Irritability	Fatigue/ Decrease in Energy	Provokes Others
Panic Attacks	Frequent Angry Outbursts	Gang Involvement
Hyperactive	Increase or loss of Appetite	School Avoidance
Runs Away	Cruelty Towards Animals	Quick Tempered
Mood Swings	Aggression Towards Others	Sexual Behaviors
Separation Anxiety	Sees Things That Aren't There	Speech Difficulties
Tearfulness	Difficulty Concentrating	Little or No Friends
Racing Thoughts	Self-Harming Behaviors / Cutting	Poor Social Skills
Breaks the Law	Frequent Stomachaches / Headaches	Binging / Purging
Bullied by Others	Suicidal Thoughts / Attempts	Cries Easily
Learning Problems	Loss of Interest in Activities	Frequent Fighting
Steals	Wets/Soils Bed or Clothes	Nightmares
Worry / Fear	Fire-Setting / Play with Fire	Hopelessness
Sadness	Problems Falling or Staying Asleep	Repetitive Movements
Disobedient / Defiant	Inattentive /Distractible	Hearing Voices

Child's School History

Current School District: _____ Grade: _____

School Name: _____ Phone #: _____

Review history of school functioning including strengths: (Gifted or accelerated learning program, learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement):

Teacher/Counselor/IEP Coordinator: _____

Is child enrolled in special education? Yes No Current IEP? Yes No (if yes, request copy)

Child is designated: Emotionally Disturbed (ED) Specific Learning Disability (SLD)

Other _____

Child's classroom is: Regular Education Regular Education with pull-out to Resource Room

Special Education classroom (all day) Inclusion in regular education (_____ hours/day)

Other: _____

What school interventions have been used to address problems?

None Special seating arrangement Tutoring Groups Classroom aide Parent(s) called

other: _____

Has the child been suspended/expelled in past 12 months? Yes No if yes, how many times and the reason(s)? _____

Child's Health

Starting with birth and proceeding up to the present, list all allergies, diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had:

Has your child ever had any previous psychotherapy? If so, where, how long, and did you feel it was helpful?

Physician Name and Number: _____

Date of Last Visit: _____

Psychiatrist Name and Number: _____

Date of Last Visit: _____

Family Relationships

Relatives That Live in the Home:	Name:	Age:	Occupation:	Describe Relationship With Child:
Father				
Mother				
Brother (s)				
Sister (s)				
Step-Father				
Step-Mother				
Step-Brother (s)				
Step-Sister (s)				
Other				
Other				

Describe any physical or mental illness that runs in the family including depression or suicide:

Please describe significant events in your family life that may have had an impact on your child (i.e. major moves, changes in school, divorce, loss of a loved one, abuse and/or assault of any kind, legal troubles):

Developmental History:

Please note the age at which the following behaviors took place.

Weaned: _____	Dry during day: _____	Dry during night: _____	Toilet trained: _____	Fed self: _____
First words: _____	Spoke sentences: _____	Sat unassisted: _____	Crawled: _____	Took first steps: _____
Dressed self: _____	Tied shoe laces: _____	Rode two-wheeled bike: _____	First Teeth: _____	Age Entered School: _____

Please describe your child's early development. Please include any complications like feeding problems, developmental delays, colic, chronic illnesses, etc.:

Signature of Client/Legal Representative

_____ Date: _____

Print Name: _____

Signature of Client/Legal Representative

_____ Date: _____

Print Name: _____