Delta Psychological & Neurobehavioral Services

CHILDREN'S PSYCHOSOCIAL
CLINICAL ASSESSMENT

Date: _____
Child's full name: _____ Birthdate: _____ Age: _____
Nickname, if any: _____ Gender: _____ Ethnicity: _____
Address: _____ Phone: _____
Guardian's name, if different from parent: _____
State in your own words the nature of your child's main problem: _____

Please answer the following questions in regard to your child:
1. Specifically why is the child being referred? Please state the questions you would like answered. _____
2. Specific background information or behavior that led to the referral? _____
3. When did the problem start? _____
4. Was there anything that happened at the time the problem began that might be related to the difficulty? _____
5. What has been your biggest concern relative to your child's physical and emotional development thus far? _____
Additional comments, treatment expectations and concerns of parents: _____

Therapist impressions:

Previous psychological treatment:

Please list any therapists and agencies that your child has been in treatment with (inpatient or outpatient) as well as the dates he/she was in treatment along with the reason for treatment.

Agency	Dates	Reason for treatment	Helpful?

Therapist impressions:

114 Tuscola Road • Bay City, Michigan 48708-6991 • (989) 895-0788 • Fax (989) 895-0799

Health history: Indicate age, severity and after effects.

Measles _____
Chicken pox _____
Whooping cough _____
Scarlet fever _____
Tuberculosis _____
Meningitis _____
Nerve disorder _____
Frequent colds _____
Tonsillitis _____
Ear ache _____
Seizures _____
Eye problems (double vision) _____
Overweight _____
Poisoning _____
Fainting spells _____
Memory issues _____

High fevers _____
Mumps _____
Allergies _____
Hay fever _____
Asthma _____
Kidney disease _____
Muscle disorder _____
Paralysis _____
Cerebral palsy _____
Epilepsy _____
Hearing problems (ringing) _____
Tongue tie clip _____
Underweight _____
Staring spells _____
Head injury _____
Suicide attempts _____

Does anyone in the family have a history of the previous or any other illnesses or handicaps? If so, please explain: _____

Medications:

Right handed _____ Left handed _____

Does your child appear to be overly bothered by:
Loud noises _____ Smells _____ Light _____ Textures/clothing _____

Are immunizations up to date? _____
Any reactions? _____

Name of family's or child's physician: _____

Please describe any serious accidents or operations the child has had: _____

Has your child ever had any of the following evaluations?

Psychological _____ Where _____ When _____
Speech _____ Where _____ When _____
Hearing _____ Where _____ When _____
Eye _____ Where _____ When _____
Neurological _____ Where _____ When _____
Physical _____ Where _____ When _____

Does your child have any handicaps (visual, auditory, speech, language, muscular)? If so, please explain: _____

Birth and prenatal history:
Is the child adopted? _____ If yes, at what age? _____
Did you receive prenatal care? _____ If yes, at which month did you first see a doctor? _____
During this pregnancy, did the mother have any unusual illnesses, conditions, or accidents? (such as German measles, false labor, spotting, swelling or water retention, toxemia, RH incompatibility, diabetes, etc?) If so, please describe: _____

Any exposure during pregnancy to toxic chemicals? _____
Any medications taken during pregnancy? If so, which? _____
How would you describe your overall mental health and physical health during pregnancy? _____

Hours of labor: _____ Was labor induced? _____
Length of pregnancy: (full term, premature, or post mature?) _____
Delivery: (C section, instruments used, easy, difficult, normal?) _____
Did child's head or feet come first? _____ Were you awake? _____
Birth weight: _____ Length: _____
After birth was the child blue? _____ jaundiced? _____ bruised or scarred? _____
Other? _____
Were there any sucking or swallowing problems? _____
Were there any breathing problems? _____
Any feeding problems? _____
Was there any difficulty during infancy with attachment or bonding between you and your child? _____

Therapist impressions:

Developmental history:

State the age at which your child did these things: (Is this from memory or record?)
Held head up _____ Sat alone _____ Crawled _____
Pulled up to standing _____ Walked alone _____
Breast fed to age _____ Bottle fed to age _____ Self weaned? _____
Used a spoon _____ fork _____ Drank from a glass/cup _____
Ate solid food _____ Special diet needs? _____
Babbled _____ Used gestures meaningfully _____
Single words _____ Phrases _____ Complete sentences _____
Bladder control: Day _____ Night _____
Training started _____ Training finished _____
Bowel control: Day _____ Night _____
Training started _____ Training finished _____
Daytime accidents to age _____ Nighttime accidents to age _____
How did the child's growth compare to that of their siblings? _____

Appetite:
Does your child have a good appetite? _____
How many meals does your child eat each day? _____
Is there excessive snacking? _____ Excessive sugar eaten? _____
Does your child have an aversion to certain types of food? _____

Sleeping habits:
Usual number of hours of sleep _____ Naptime _____ Bedtime _____
Time child goes to bed _____ Time child wakes up in the morning _____
Does your child seem to require a lot of sleep (more than 12 hours a day) or little sleep (less than 8 hours a day) _____
Where does your child usually sleep (crib, junior bed, adult bed): _____
Does your child sleep alone? _____ Does your child sleep well? _____
Does your child have a routine at bedtime? _____
Any sleeping problems? _____

Juvenile history:
Has your child ever been arrested or appeared in Juvenile Court? _____
_____

Has your child ever been removed from your care and placed in foster care? _____
_____

Therapist impressions:

Therapist, include any substance abuse history if applicable.

Family history:
Mother's name: _____ Birthdate: _____
Occupation: _____ State of health: _____
Father's name: _____ Birthdate: _____
Occupation: _____ State of health: _____
Are both parents in the home? _____ Separated or divorced? _____
Death of a parent? _____ Visits by other parent? _____
Step-parent? _____ Foster parent? _____
Age of child at time of divorce or death, if applicable: _____
Age of child at remarriage _____ Length of present marriage _____

Brother and sisters: Please list all children including step and half siblings. Please check (X) the name if they live outside the home.

Name	Birthdate	Age	Grade	Areas of difficulty in school

Others living in home: _____

Social development:
How does your child get along in the home? _____
How does your child get along with mother? _____
Father? _____
Brothers? _____
Sisters? _____
Adults? _____
Strangers? _____
Children child's own age? _____
Younger? _____
Older? _____
Pets? _____
Do you see any changes occurring? _____
Any strong attachment outside of the home? _____
Time spent watching TV each day _____
Does your child dress itself? _____ How much help do they need? _____
Ever put wrong arm in sleeve? _____ Selects their own clothes? _____
Can child leave the yard? _____ Permission required? _____
What kind of toys and play does your child like the most? _____
By self _____ With others _____ Shares well? _____
Does your child help with simple jobs, like picking up toys? _____
What chores does your child have? _____

Does your child share feelings easily? _____ Pain? _____ Anger? _____
Any fears, please describe: _____
Any nursery school experience? _____
What does your child like to do for fun? _____

Therapist impressions:

Therapist: Any cultural issues to be addressed?

Personal characteristics:

Very active	_____	Frequent accidents	_____	Loses balance easily	_____
Very calm, quiet	_____	Restless	_____	Unusual walk	_____
Difficulty sitting still	_____	Nervous or tense	_____	Affectionate	_____
Good natured	_____	Easily angered	_____	Cries easily	_____
Frequent mood changes	_____	Grew rapidly	_____	Grew slowly	_____
Rocks body back and forth (sitting)	_____	Long periods of little or no growth	_____		
Rocks body while standing	_____	Uncontrolled facial jerks	_____		
Difficulties chewing or swallowing	_____	Speech difficulties: describe	_____		
Clumsy or awkward	_____	Poor eating habits: describe:	_____		
Excessive talkativeness	_____	Frequently ill	_____	Separation anxiety	_____
Suicidal ideations	_____	Homicidal ideations	_____		

Therapist impressions:

Discipline:
What type of discipline do you use most often?
Talk with child _____ Physical _____
Persuasion _____ Reasoning _____
Taking away privileges _____ Other _____
Who disciplines most? _____ Agreement on discipline? _____
Any big changes in discipline methods by you or others? _____
Do you have problems with management or controlling your child? _____
Describe your child's reactions to discipline (does it work?) _____

Therapist impressions:

School:
Current grade level in school _____
Average grades received: Last term _____ Now _____
Current goals in school _____
Special education? _____
Has your child ever been held back or skipped a grade? _____ Which grade? _____
What was the reason: _____
Any problems in school behavior reported to you by teachers? _____
Any suspensions? _____
When? _____

How does your child get along with children in school? _____
Has your child ever gotten into trouble due to stealing? _____ Drugs/ alcohol? _____
Has your child ever been in trouble for threatening other students? _____

Therapist impressions:

_____ _____
Signature of parent/ guardian Date Signature of interviewing therapist Date
Orientation conducted: _____