Children & Youth Assessment

Child/Youth's Name: _____ DOB: _____

Father's Name: _____ Occupation: _____

Employer: _____ Highest Level of Education: _____

Mother's Name: _____ Occupation: _____

Employer: _____ Highest Level of Education: _____

List other members of the household and their relationship to the child:

Name	Relationship	Age	School & Grade	Learning or Behavioral Issues

Are there any other family members living out of the child's home?

_____

Has the child experienced any of the following?

□ Moving? How many times?_____ When? _____

□ Long visits with relatives? If so, whom? _____ When? _____

□ Living with someone other than a parent If so, whom? _____ When? _____

□ Death in the family If so, whom? _____ When? _____

□ Terminal or chronic illness If so, whom? _____ What type of illness? _____

□ Parental separation and/or divorce When? _____

□ New step-parent Which parent re-married? _____ When? _____

□ Other traumatic or upsetting experience Explain: _____

DEVELOPMENTAL HISTORY

PREGNANCY & DELIVERY:

Prenatal Care: ☐ Adequate ☐ Inadequate ☐ Unknown

Significant illnesses (mother): _____

Perinatal Events: Was child premature? ☐ Yes ☐ No ☐ Unknown

Birth Weight: _____ Birth Height: _____

Birth Complications? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

FIRST YEAR:

Breast Fed? ☐ Yes ☐ No ☐ Unknown If Yes, how long? _____

Allergies? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

Problematic Sleep Patterns? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

MILESTONES: (Give approximate age if known)

_____ Sat without Support _____ Crawled _____Walked with Assistance

_____ Ate with a Fork _____ Toilet Trained _____ Able to Dress Self

_____ Said first Word _____ Used Sentences

If unable to remember specific dates, were milestones reached Within Normal Limits? ☐ Yes ☐ No ☐ Unknown

Prenatal History

Did the mother receive regular prenatal care? □ Yes □ No

Were there any illnesses or problems during pregnancy for the child or the mother? □ Yes □ No

Explain: _____

Were any medications or drugs taken during pregnancy? □ Yes □ No

Explain: _____

Does the child have difficulty with any of the following:

□ Balance □ Throwing a ball □ Skipping □ Writing/coloring □ Buttoning □ Memory

□ Following instructions □ Understanding what others are saying □ Paying attention/staying focused

Explain: _____

MEDICATION

Is the child currently taking any medications? □ Yes □ No If Yes, please list medication

Medication Physician Reason How long has the child been taking this medication?

_____

_____

_____

Has the child ever been prescribed any additional medication for conditions other than common childhood illnesses?

_____

Has anyone in the child's family been diagnosed as having any chronic medical or emotional disorders?

Explain:

_____

_____

Did either of the child's parents have a learning disability or behavior concerns during childhood?

Explain:

_____

_____

Social-Emotional History

Did the child attend pre-school? □ Yes □ No If so, where and when? _____

Where does the child attend school? _____ Grade? _____

Does the child have an IEP? □ Yes □ No Reason: _____

Who handles the discipline in the home? _____

What methods of discipline are most effective with the child? _____

_____

Does the child exhibit any of these behaviors frequently at home or within the community?

□ Shyness □ Unable to make/keep friends □ Prefers to play alone □ Cries easily □ Irritable

□ Very independent □ Fearful □ Harms pets/animals □ Plays with sex organs or other body parts

□ Insists on his/her own way □ Physical ailments/complaints □ Unable to show feelings □ Indecisive

□ Threatens to harm self □ Threatens to harm others □ Shows preoccupation with fire □ Nightmares

□ Hand waving or flapping □ Runaway □ Rocking □ Head banging □ Quick temper □ Bites

□ Lies, steals, and/or cheats □ Difficult to discipline □ Nail biting □ Thumb sucking □ Talks baby talk

□ Overactive □ Always worried □ Daydreams □ Easily distracted □ Destructive □ Accident prone

□ Other unusual behavior_____

If so, explain: _____

Has this child ever seen a counselor (including a school counselor)? □ Yes □ No

If so, list the names and contact numbers for any providers or professionals who have pertinent information about your child (i.e.- pediatrician prescribing psychotropic medications, community mental health agencies, school counselor, etc.).

_____

_____