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Assessment Questionnaire [Ages 18 and under]

CONFIDENTIAL ONCE COMPLETED

Date _____ Form completed by: _____

Child/Youth's Name _____ DOB _____

Address _____

Home Phone _____ Emergency Contact _____

Reason for concern? _____

How do you want this child/youth's situation to be different? _____

What have you or this child/youth already done or tried to do to address this issue? _____

Has this child/youth ever been in counselling or therapy before? ___ Yes ___ No

If yes:

Name of Provider	Clinic	Year	Diagnosis / Problem
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Has this child/youth been prescribed medication? ___ Yes ___ No

If yes:

Medication	Dosage	Prescribed by	Still taking?
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Check if this child/youth has been involved in:

- | | |
|---|--|
| <input type="checkbox"/> Inpatient mental health care | <input type="checkbox"/> Substance abuse program |
| <input type="checkbox"/> Day treatment | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Psychiatric Assessment |

Please explain below if any of the above apply to this child/youth's situation or history:

Has this child/youth ever:

Made a suicide attempt? If yes, when _____

Expressed homicidal thoughts? If yes, describe _____

Had episodes of explosive behavior? If yes, describe _____

Is this child/youth currently expressing homicidal / suicidal feelings? Yes No

Please note that there are limits to confidentiality, and I may need to break confidentiality under certain circumstances including if there is reason to believe that risk of harm to self exists, or harm to someone else. I will act discretely should this situation arise, and the intent of my actions will always be to serve the best interest of the child/youth.

Describe child/youth's health generally: good fair poor

Is this child/youth sexually active: yes no

List any health problems that the child/youth has had: _____

Check if this child/youth has:

- | | | |
|--|---|---|
| <input type="checkbox"/> Current immunizations | <input type="checkbox"/> A disability | <input type="checkbox"/> Hospitalizations |
| <input type="checkbox"/> Any allergies | <input type="checkbox"/> Sleep problems | |
| <input type="checkbox"/> Nutritional problems | <input type="checkbox"/> Any accidents / injuries | |
| <input type="checkbox"/> Appetite problems | <input type="checkbox"/> Dental, vision or hearing problems | |

If yes to any of the above, please explain: _____

Physician: _____ Telephone: _____

Date of last contact and reason for contact: _____

Date of last full physical examination _____

Family Information

Family Members [please include parents / step-parents / siblings]

Name	Age	Relationship to Child/Youth	Living in same home?	Occupation

Was this child/youth adopted? ___yes ___no
Has this child/youth ever been placed outside of the home ___yes ___no
In how many residences has this child/youth lived _____

Has this child/youth ben physically or sexually abused, assaulted or molested
___yes ___no ___don't know
If yes, by whom & when _____

Are there any other family members who have / had mental health or emotional problems?
Family Member Mental Health Issue / Diagnosis, and any other details

Pregnancy and Delivery Information

Was this a planned pregnancy ___ yes ___no Normal pregnancy ___yes ___no
Was pregnancy easy ___yes ___no Length of pregnancy _____months
Birth weight _____lbs. _____oz. Was baby premature ___yes ___no
Type of delivery ___spontaneous ___forceps ___cesarean
Was infant born ___head first ___feet first ___breech
Was oxygen necessary ___yes ___no

If mother was ill during pregnancy, please explain including treatment or medications

Infancy: Breast fed? If yes, how long _____

Did infant feed well? _____

Weight gain normal? _____

Was there ever any head banging, rocking, thumb sucking, teeth grinding, extreme of temper tantrums? ____ yes ____no

If yes, please explain _____

	Within Normal Limits?		If no, please explain...
Motor development and functioning	Yes	No	
Speech, hearing and language functioning	Yes	No	
Visual functioning	Yes	No	

Was there any issues / traumas / situations in this child / youth's life that may have contributed to the present reasons for seeking assistance?

Substance Use: Please complete the chart below:

Category of drug	Has child/youth used	Currently using?	Age of first use?	How often?	How much?	Use in last 48 hours?	Withdrawal symptoms?
alcohol							
stimulants							
cocaine							
tranquilizers							
barbiturates							
marijuana							
opioids							
hallucinogen							
prescribed							
nicotine							
caffeine							
other							

Legal Information

Has this child/youth ever: Had difficulty or contact with police ___yes ___no
Appeared in juvenile court ___yes ___no
Been on probation ___yes ___no

If yes, please explain: _____

Daycare Information

Does child attend day care or have a caregiver? ___yes ___no

If yes, are there any issues as described by the day care staff or caregiver? Please explain:

What has been attempted to address issue[s] in day care or with caregiver?

School Information

School: _____ Grade level: _____

Is this child/youth currently in a special program? ___yes ___no

Has this child/youth ever:

___Been in a special class ___Been expelled
___Been tutored ___Been suspended

Give the average grade received in school in last six months _____

Does this child/youth enjoy school ___yes ___no ___somewhat

Please explain child/youth’s feelings towards school _____

How do you describe the child/youth’s friendships:

___no friends ___only acquaintances ___both friends and acquaintances

How many close friends _____ Please use back of page to describe any social issues —>