Psychosocial Assessment

Name_____ Age_____ Date of Birth_____

Please complete the following assessment about your child/adolescent as thoroughly as possible.

Please describe the problems or circumstances that contributed to seeking counseling?

_____
_____
_____
_____

What changes would you like to see in your child as a result of counseling?

_____
_____
_____
_____

Please indicate the following symptoms your child has experienced:

Symptom	**How Long?**
__*Anxiety*	_____
__*Depressed Mood*	_____
__*Low Energy Level*	_____
__*Racing Thoughts*	_____
__*Poor Concentration*	_____
__*Indecisiveness*	_____
__*Change in sleeping: increased/decreased*	_____
__*Change in appetite: increased/decreased*	_____
__*Angry Outbursts*	_____
__*Crying Spells*	_____
__*Lack of Motivation*	_____
__*Weight Change: gain/loss*	_____
__*Feeling others are against you*	_____
__*Excessive Guilt*	_____
__*Isolation*	_____
__*Mood Swings*	_____
__*Feelings of Hopelessness*	_____
__*Low Self-Esteem*	_____
__*Difficulty with Memory*	_____
__*Thoughts/Plans of Suicide*	_____
__*Self Harm Behaviors*	_____
__*Thoughts/Plans of harming other*	_____
__*Alcohol Use*	_____
__*Drug Use: Type*_____	_____
__*Tobacco Use*	_____
__*Bedwetting*	_____
__*Soiled Pants*	_____
__*Trouble in School*	_____

__*Truancy* _____
__*Social Difficulty* _____
__*Bullying* _____
__*Conflict with Family* _____
__*Running Away* _____
__*Problems with the law* _____
__*Rocking* _____
__*Head Banging* _____
__*Destructive* _____
__*Fire setting* _____
__*Harm to Animals* _____
__*Infantile* _____
__*Sexual Behavior* _____
__*Lying* _____
__*Overactive* _____
__*Fearful* _____
__*Impulsive* _____
__*Phobic* _____
__*Poor boundaries* _____
__*Defiant* _____
__*Oppositional* _____
__*Difficulty adjusting to changes* _____
__*Sensory issues* _____
__*Hallucinations* _____
__*Nightmares* _____
__*Withdrawn* _____
__*Problems with eye contact* _____
__*Lack of empathy* _____
__*Other*_____ _____
__*Other*_____ _____
__*Other*_____ _____

Has your child been the victim of sexual, physical, emotional abuse or neglect? Yes/No

If yes, what type of abuse?_____
When did it happen?_____
Who was the perpetrator?_____
Was this abuse ever reported or investigated? Please include dates.
_____
_____

Culture

What is your child's:

Race _____
Ethnicity _____
Cultural Background _____

Where was your child born? _____

How many times has your child moved? _____

Where has your child lived?

_____ age when living there___ to ___
_____ age when living there___ to ___
_____ age when living there___ to ___
_____ age when living there___ to ___

What is the socioeconomic class of your household?

__ Lower Class __ Middle Class __Upper Middle __ Upper Class

Are there any cultural sensitivities that your counselor should be aware of?

_____
_____

Family

Please complete the following about Biological Parents (if unknown, complete for Adopted Parents)

Father_____ Age_____ Marital Status _____
Occupation_____ Location_____
Deceased? Y/N If deceased, cause of death_____
Describe the relationship the child has/had with his/her father._____
_____
_____

Mother_____ Age_____ Marital Status _____
Occupation_____ Location_____
Deceased? Y/N If deceased, cause of death_____
Describe the relationship the child has/had with his/her mother.
_____
_____

Please identify any history of divorce and/or remarriage as related to the child's parents including dates.
_____
_____
_____

Please identify any relationships the child has had with step-parents or parent's significant others.
_____
_____

Describe any criminal history associated with either parents or step-parents.
_____
_____

Siblings

Please list all siblings in birth order. Please indicate if the sibling is "half" of "step".
Name_____ Age___ Sex____ Relationship_____ Living in the home? Y/N
Name_____ Age___ Sex____ Relationship_____ Living in the home? Y/N

Name_____ Age___ Sex____ Relationship_____ Living in the home? Y/N
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Name_____ Age___ Sex____ Relationship_____ Living in the home? Y/N
Name_____ Age___ Sex____ Relationship_____ Living in the home? Y/N

Please list any other people living in your home and please describe the relationship
Name_____Age_____ Relationship_____
Name_____Age_____ Relationship_____
Name_____Age_____ Relationship_____

Adoption

Was your child adopted? Yes/ No

If yes, please explain reason and circumstance for adoption. _____
_____

Source of adoption _____

Date and age of child when adopted? _____

What has your child been told?_____

Does your child have any knowledge of, or contact with biological parents?_____

Was your child ever in foster care? Yes/No
If yes, please indicate approximate age and time period._____
_____

How has your child responded/adapted to the adoption?_____
_____

Family History

Please complete the following to include immediate and extended family.

Describe any history of physical illness in your child's family.
_____
_____
_____

Describe any history of psychiatric disorders or emotional disturbance in your child's family.
_____
_____

Describe any history of alcohol or drug abuse/addiction in your child's family.
_____
_____

Describe any history of sexual, physical, or emotional abuse in your child's family.
_____
_____
_____

Medical History

Describe any health issues that your child has experienced.

_____
_____
_____

Has your child been diagnosed with a psychological disorder? Yes/No

Diagnosis _____ Physician_____
Diagnosis _____ Physician_____

Does your child see a psychiatrist? Yes/ No

Current Psychiatrist: _____ For how long? _____
Previous Psychiatrist: _____For how long? _____

Please list any **psychiatric** medication that your child is currently taking/prescribed:

Medication:_____ Dosage _____ Reason_____ How long_____
Medication:_____ Dosage _____ Reason_____ How long_____
Medication:_____ Dosage _____ Reason_____ How long_____
Medication:_____ Dosage _____ Reason_____ How long_____

Name of Prescribing Physician _____

Please list any **other** medications that your child is taking/prescribed?

Medication:_____ Dosage _____ Reason_____ How long_____
Medication:_____ Dosage _____ Reason_____ How long_____
Medication:_____ Dosage _____ Reason_____ How long_____
Medication:_____ Dosage _____ Reason_____ How long_____
Medication:_____ Dosage _____ Reason_____ How long_____

Name of Prescribing Physician _____

Has your child received counseling or other treatment in the past? Yes / No
If yes, please explain and include counselor/treatment facility name and time period of treatment (month/year).

_____
_____
_____

Has your child had a history self harming behavior or suicide attempts? Yes/No
If yes, please explain in detail (dates when possible).

_____
_____
_____

Please identify any history of hospitalization as related to your child.

_____
_____

Developmental History

Has your child experienced any developmental delay? Yes /No
If yes, please explain.

_____
_____

Did the child's mother have any problems during pregnancy or childbirth? Yes/ No
If yes, please explain. _____
_____

Describe any issues that your child may have experienced concerning attachment.

_____
_____
_____

What do you perceive to be your child's greatest strengths?

_____
_____
_____

Religious Affiliation and History

Are you a Christian family? Yes/ No

If yes, how long have you been a Christian? _____ Your child? _____
If not, what other religion/belief? Family?_____ Child?_____

Describe the role God has had, if any, in your current home environment where your child resides.

_____
_____

What churches or denominations have you primarily attended?

_____
_____

Describe your view of/ relationship with God.

_____
_____

How comfortable are your with incorporating your faith into the counseling process? With prayer?

_____
_____
_____