

LIST PSYCHOLOGICAL SERVICES, PLC
ADOLESCENT PSYCHOSOCIAL ASSESSMENT

CA BC Wilder LPR SAG Center BC Washington Huron

If parent is completing, please answer for the adolescent.

GENERAL INFORMATION:

Date: _____ Client Name: _____ Gender: M F
Age: _____ Birth Date: _____ With whom do you live? _____
Mother's Full Name _____ Custody? Physical Legal Visitation
Father's Full Name _____ Custody? Physical Legal Visitation
Alternate Guardian _____ Type of Guardianship? Relative Foster
*Did you bring a copy of the most recent court order regarding parenting time and custody? Yes No

Why are you seeking services at this time: _____

FAMILY HISTORY:

- Who are you being raised by (check all that apply): Biological mother Biological father
 Stepmother Stepfather Other: _____
- How many brothers and sisters do you have? _____
- Briefly describe how you get along with others in your family (ie. Brothers, sisters, parents) _____

- Have you ever lived away from your parents? Yes No If yes, explain _____

- Is there a history of mental illness in the family? Yes No If yes, who and what kind of problems? _____

- Have any family members committed suicide? No Yes, Who? _____
- Is there a history of drug and/or alcohol problems in the family? No Yes, who and what kind of substance? _____

- Please describe the family in which you were raised. _____
- Do you identify with a particular ethnic group? Yes No If yes, please name: _____
- Do you identify with a particular religious group? Yes No If yes, which one: _____
- Have you experienced any difficulties related to your culture, ethnicity or religious affiliation? Yes No
If yes, please explain: _____

RELATIONSHIPS:

- Present relationship status: Engaged Boyfriend Girlfriend No Significant Relationship
- If dating, how long with current partner? _____
 - Are you currently or have you experienced any physical, emotional, or sexual abuse in your relationship(s)? If yes, please explain. _____
 - How many children do you have? _____ What are their ages? _____
 - Do you feel you have enough good friends? Yes No How many do you have? _____
 - How easy do you make friends? _____
 - What issues with friends are currently concerning you or your child? _____

EDUCATION/EMPLOYMENT HISTORY:

- Current school(s) _____ Grade level _____
- What are your current grades? A's B's C's D's E's
- Are there any school attendance issues? Yes No If yes, explain. _____
- Have you ever had speech and language therapy? No Yes, where and when? _____
- Check all that apply regarding your school experience: gifted classes special education school suspensions
 problems with classmates/bullying problems with teachers cheating extracurricular activities
- Do you have any learning problems? Yes No If yes, what are the problems? _____
- Do you have a job? Yes No If yes, what is your job? _____
- Do you have any other sources of income? If yes, please list. Yes No _____
- Do you have any current job issues? Yes No _____
- Do you have problems with focus or attentiveness? Yes No
- Do you have problems staying seated? Yes No

DEVELOPMENTAL/MEDICAL HISTORY:

- Length of Mother's pregnancy for you? premature full-term post-term Birth weight _____
- Were there any complications during pregnancy and/or during/after birth? (ie. Jaundice, head injury, etc) _____
- Did your Mother use substances during pregnancy? Yes No If yes, please list. _____
- Developmental Milestones (please list age when accomplished)? Crawl _____ Walk _____ Single word _____
 2 words+ _____ Bladder trained? day _____ night _____ Bowel trained? day _____ night _____
- Has there been a history of bedwetting? Yes No If yes, explain; _____
- Has there been a history of soiling? Yes No If yes, explain; _____
- Hearing issues? Yes No If yes, explain _____
- Vision issues? Yes No If yes, explain _____
- Dental issues? Yes No If yes, explain _____
- Medical Primary Care Physician: _____ Date last seen: _____
- How do you rate your general health? poor fair average good excellent
- Immunizations up to date? Yes No If no, explain? _____
- What, if any, medical problems do you have (such as asthma, diabetes)? _____
- Are you currently taking medications? Yes No If yes, what medications? _____
- Drug allergies/adverse reactions/side effects _____
- Do you have any concerns related to your weight? _____
- Has your weight change over the last year? No Yes Lost _____ lbs. Gained _____ lbs.
- How many meals do you eat a day? _____ Do you have any changes in eating habits/appetite? Yes No
 If yes, please describe: _____
- Do you currently participate in any type of exercise/physical activity? If yes, please describe: _____
- Caffeine Use: How many cups, cans or glasses of caffeinated beverages per day do you drink? _____
- Do you currently use any tobacco products? If yes, describe _____
- Have you had any head injuries or loss of consciousness? Yes No If yes, explain: _____
- Have you had any surgeries? Yes No If yes, please list dates and what type: _____
- Do you or have you ever struggled with eating issues such as bingeing, purging, compulsive overeating or going days without eating? If yes, please describe. _____

PSYCHIATRIC HISTORY:

- Describe your personality (i.e. aggressive, calm, shy, high energy) _____
- Have you been in counseling before? Yes No If yes, what type and when: _____
- Have you ever been hospitalized for psychiatric reasons? Yes No If yes, where and when: _____
- Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you are affected in each area by circling the appropriate number (please circle only one number for each item).

NO PROBLEM #1	SOMEWHAT OF A PROBLEM #2	MODERATE PROBLEM #3	SERIOUS PROBLEM #4	SEVERE PROBLEM #5
Depression (sadness, loss of interest, etc)	1 2 3 4 5		Sudden Change in mood	1 2 3 4 5
Anxiety (nervousness, panic, excessive worry)	1 2 3 4 5		Lack of energy	1 2 3 4 5
Anger control problems	1 2 3 4 5		Not liking self	1 2 3 4 5
Hallucinations (hearing voices/seeing things)	1 2 3 4 5		Not liking others	1 2 3 4 5
Thoughts of homicide	1 2 3 4 5		Withdrawal from others	1 2 3 4 5
Thoughts of suicide	1 2 3 4 5		*Problems with sleep	1 2 3 4 5
*Suicide attempts	1 2 3 4 5		Nightmares	1 2 3 4 5
*Obsessions or compulsions	1 2 3 4 5		Overly suspicious	1 2 3 4 5
*Serious trauma	1 2 3 4 5		Problems with boy/girlfriend	1 2 3 4 5
*Self-abusive behaviors	1 2 3 4 5		Problems with friends	1 2 3 4 5
Hyperactivity	1 2 3 4 5		Problems with gambling	1 2 3 4 5
Impulsivity	1 2 3 4 5			

*Explain _____

- Who do you rely on for support? (ie, spouse, parents, coworkers, etc) _____

BEHAVIOR:

- Do you have concerns about your behavior? Yes No If yes, explain _____
- Describe any changes in your behavior in the past year _____
- What disciplinary methods are commonly used and how effective are they? _____
- Who usually disciplines you? _____
- Are you using illegal substances or do your parents/guardian suspect you of this behavior? Yes No If yes, explain: _____

Please complete the following regarding your drug/alcohol use history:

SUBSTANCES USED/ABUSED (such as alcohol, marijuana, vicodin, etc)	AGE OF 1 ST USE	YEARS OF USE	LAST DATE OF USE	AMOUNT USED	FREQUENCY OF USE

What is your substance of preference? _____

Please answer the following questions:

- Yes No I have overdosed from drugs/alcohol.
- Yes No I have felt bad or guilty about my use of drugs/alcohol.
- Yes No Family members complain about my drug/alcohol use.
- Yes No My drug/alcohol use has created problems for my family.
- Yes No I lost friends because of my drug/alcohol use.
- Yes No I neglected my family because of my drug/alcohol use.
- Yes No I got in trouble at work/school because of my drug/alcohol use.
- Yes No I got in physical fights while under the influence of drugs/alcohol.

• Have you received treatment for a substance abuse problem before? Yes No If yes, explain _____

• Were you ever arrested, convicted or placed on probation? Yes No If yes, describe below:

Age _____ Offense _____

Age _____ Offense _____

• Are you currently on Probation/Parole? Yes No If yes, describe and give PO name: _____

Parent/Guardian Signature

Date