

LIST PSYCHOLOGICAL SERVICES, PLC
CHILD PSYCHOSOCIAL ASSESSMENT

CA BC Wilder LPR SAG Center BC Washington Huron

If parent is completing, please answer for the child.

GENERAL INFORMATION:

Date: _____ Client Name: _____ Gender: M F
Age: _____ Birth Date: _____ Whom does the child live with? _____
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 for your child at this time: _____

FAMILY HISTORY:

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

- Has your child ever lived away from 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? _____

- Describe the family in which the child is being raised. _____
- Does your child identify with a particular ethnic group? Yes No If yes, please name: _____
- Does your child identify with a particular religious group? Yes No If yes, which one: _____
- Has your child experienced any difficulties related to their culture, ethnicity or religious affiliation? Yes No
If yes, please explain: _____

EDUCATION/EMPLOYMENT HISTORY:

- Current school(s) _____ Grade level _____
- What are your child's current grades? A's B's C's D's E's
- Are there any school attendance issues? Yes No If yes, explain. _____
- Has your child ever had speech and language therapy? No Yes, where and when? _____

- Check all that apply regarding school experience: gifted classes special education school suspensions
 problems with classmates/bullying problems with teachers cheating extracurricular activities
- Does your child have any learning problems? Yes No If yes, what are the problems? _____

- Does your child have problems with focus or attentiveness? Yes No
- Does your child have problems staying seated? Yes No

BEHAVIOR:

- Do you have concerns about your child’s behavior? Yes No If yes, explain _____
- Describe any changes in your child’s behavior in the past year _____
- What disciplinary methods are commonly used and how effective are they? _____
- Who usually disciplines your child? _____

DEVELOPMENTAL/MEDICAL HISTORY:

- Length of Mother’s pregnancy for the child? premature full-term post-term Birth weight _____
- Were there any complications during pregnancy and/or during/after birth? (ie. Jaundice, head injury, etc) _____
- Did 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 would you rate the child’s general health? poor fair average good excellent
- Immunizations up to date? Yes No If no, explain? _____
- What, if any, medical problems does the child have (such as asthma, diabetes)? _____
- Is the child currently taking medications? Yes No If yes, what medications? _____
- Drug allergies/adverse reactions/side effects _____
- Are there any concerns related to your child’s weight? _____
- Has child’s weight change over the last year? No Yes Lost _____lbs. Gained _____lbs.
- How many meals does your child eat a day? _____
- Are there any changes in the child’s eating habits/appetite? Yes No If yes, please describe: _____
- Does your child 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 does your child drink? _____
- Has your child had any head injuries or loss of consciousness? Yes No If yes, explain: _____
- Has your child had any surgeries? Yes No If yes, please list dates and what type: _____
- Is your child or has your child ever struggled with eating issues such as bingeing, purging, compulsive overeating or going days without eating? If yes, please describe. _____

PSYCHIATRIC HISTORY:

- Describe your child’s personality (i.e. aggressive, calm, shy, high energy) _____
- Has your child been in counseling before? Yes No If yes, what type and when: _____

- Has your child 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 your child is 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 friends	1 2 3 4 5
*Self-abusive behaviors	1 2 3 4 5		Impulsivity	1 2 3 4 5
Hyperactivity	1 2 3 4 5			

*Explain _____

- Who does your child rely on for support? (ie, spouse, parents, teachers, etc) _____

Parent/Guardian Signature

Date