

Child/Adolescent Comprehensive Strength Based Assessment

Evaluation Date: _____

Client Information

Child's Name: _____

Date of Birth: _____

Age: _____ Male _____ Female

Eye Color _____ Ethnicity: _____

Address: _____

County: _____

Phone Number: _____

Alternative # _____

Insurance: Primary _____ ID # _____

Grp # _____

Card Holder Name _____ Card Holder Date of Birth: _____
(If other than child)

Secondary Insurance (Medical Assistance) _____ 10 Digit # _____

Social Security #: _____

Family Information

Biological Mother's Name: _____ Age: _____

Place of Residence: _____

Marital Status (please circle): Married; Divorced; Separated; Single; Never Married;
Re-Married

Stepparent name (if applicable) _____

Biological Father's Name: _____ Age: _____

Place of Residence: _____

Marital Status (please circle): Married; Divorced; Separated; Single; Never Married;
Re-Married

Stepparent name (if applicable) _____

Who has physical custody of the child? _____

Legal Guardianship: _____

Please list all those who live in the home with child:

Name	Age	Relationship	Special Needs
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent Occupation:

Mother/Guardian: _____

Father/Guardian: _____

Family's Religious Affiliation:

Any siblings outside of the home:

School Information

School: _____

School District: _____

Grade: _____

Special Education: No Yes: Type: Learning Support
Emotional Support

Health / Medication / Mental Health

Any previous diagnoses?: No Yes. Please specify: _____

Current Medications:

Name	Dose
_____	_____
_____	_____
_____	_____

Past Medications:

Name	Reason discontinued
_____	_____
_____	_____
_____	_____

Who prescribes the medication: _____

Child's Pediatrician: _____

Pediatricians Phone # _____

Medical Conditions (If yes, please describe)

- Allergies No Yes: Type-
- Asthma No Yes
- Seizures No Yes: Type-
- Hearing deficits (hearing aide?) No Yes
- Vision deficits (glasses?) No Yes
- Serious medical conditions? No Yes
- Head Trauma No Yes
- Loss of consciousness No Yes
- Prolonged high fever? No Yes

Has your child ever needed medical care or surgery for an illness or injury? _____

If so please describe:

Services

Any history of behavioral health services? _____ No _____ Yes

If yes, please specify type (outpatient counseling, wraparound...):

Any current behavioral health services? _____ No _____ Yes

If yes, please specify type (outpatient counseling, wraparound...):

The agency's name providing the services: _____

Who referred your child for evaluation (person or agency)?

CURRENT CONCERNS (Please check-mark those that apply)

Family Instability / Trauma / Abuse

- Physical Abuse Sexual Abuse
- Witness of domestic violence Witness of parental substance abuse
- Foster care Out of home placement
- Neglect Children-Youth services involvement
- Parent Incarceration

Please check all that apply:

- Speech/Language difficulties (limited vocabulary; talks in short phrases...)
- Not wanting to socialize
- Not knowing how to socialize
- Poor eye contact

Lack of imagination/play skills (not knowing how to play)

Odd Behaviors:

- hand-flapping
- rocking
- bouncing/hopping
- echoing others (repeating)
- toe-walking
- lining-up of objects
- spinning objects or themselves
- fascination with moving objects (fans, trains...)
- obsessing on topics
- repeating words and phrases from videos (scripting)
- immediately repeating words of others (echoing others)
- Difficulty with changes in routine or unexpected events
- Extra sensitive to clothing, sound, food, textures, light...
- Seems to seek sensory stimulation by bumping into things, wanting firm hugs...
- Restricted food preferences

Behavioral Problems

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Defiance | <input type="checkbox"/> Ignoring of direction | <input type="checkbox"/> Tantrums |
| <input type="checkbox"/> Back-talk | <input type="checkbox"/> Physical aggression | |
| <input type="checkbox"/> Verbal Aggression | <input type="checkbox"/> Destruction of property | |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Impulsivity | |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Deficient grooming and hygiene | |
| <input type="checkbox"/> Difficult community behavior | <input type="checkbox"/> Tough time doing homework | |

Emotional Problems

- | | |
|--|--|
| <input type="checkbox"/> Appears depressed | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Compulsions (doing things over and over) |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Talk of wanting hurt self or not be alive |
| <input type="checkbox"/> Self-Injurious behavior | <input type="checkbox"/> Psychiatric hospitalization |

Social Problems

- | | |
|--|--|
| <input type="checkbox"/> Difficulty establishing friendships | |
| <input type="checkbox"/> Difficulty maintaining friendships | <input type="checkbox"/> Alienated by peers |
| <input type="checkbox"/> Arguments with peers | <input type="checkbox"/> Withdraws from peers |
| <input type="checkbox"/> Physical confrontations with peers | <input type="checkbox"/> Social phobia (extreme fear of social situations) |

School problems

- | | |
|---|--|
| <input type="checkbox"/> Underachievement | <input type="checkbox"/> School refusal |
| <input type="checkbox"/> Behavior problems in school | <input type="checkbox"/> Suspensions |
| <input type="checkbox"/> After-School Detentions | <input type="checkbox"/> Threat of expulsion |
| <input type="checkbox"/> Lunch/Recess Detentions | <input type="checkbox"/> Poor grades |
| <input type="checkbox"/> Problems reading | <input type="checkbox"/> Problems with math |
| <input type="checkbox"/> Problems writing | <input type="checkbox"/> Leaves homework at home |
| <input type="checkbox"/> Does not turn-in homework | <input type="checkbox"/> Being bullied |
| <input type="checkbox"/> Does not bring homework home | |

Food Issues

- | | |
|---|---|
| <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Finicky |
| <input type="checkbox"/> Over-eating | <input type="checkbox"/> Excessive time to eat meals |
| <input type="checkbox"/> Bingeing (eating large amts of food all at once) | <input type="checkbox"/> Putting too much food in mouth at once |
| <input type="checkbox"/> Purging | <input type="checkbox"/> Choking/Gagging |
| <input type="checkbox"/> Low calorie intake | <input type="checkbox"/> Can't sit through a meal |
| | <input type="checkbox"/> Uses eating utensils |

Delinquency

- | | |
|---|--|
| <input type="checkbox"/> Problems with the police | <input type="checkbox"/> Running away from home |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Marijuana use |
| <input type="checkbox"/> Cigarette use | <input type="checkbox"/> Stealing from home/community (stores) |
| <input type="checkbox"/> Probation | |

Self-care: How well can your child take care of him/herself? (dressing, playing, eating, etc.)

Birth and Early Development

Any complications during pregnancy/delivery: No _____
Yes _____ If Yes, please explain:

Any substances used during the pregnancy? ___ Yes ___ No

Full-term: Yes / No

Birth Wt: Pounds: _____ ozs. _____ Born Healthy: Yes / No:

Mom and Child discharged together: Yes / No

Infant temperament: _____ Calm and Pleasant; _____ Fussy

Any serious illnesses during infancy? ___ Yes ___ No If so please explain:

Developmental Milestones

Walked independently by one year of age: Yes / No

Began expressing words and short phrases by two years of age: Yes / No

Toilet trained on time: N/A Urination: Yes / No Bowel Movements: Yes / No

Any history of parental substance abuse? ___ Yes ___ No

Any history of domestic violence? ___ Yes ___ No

History of child experiencing any trauma or abuse (N / Y) Specify:

History of child being psychiatrically hospitalized (N / Y)

Your child was how old when you first began to have concerns about his/her behavior: ___

What were your first concerns?

How does the family respond?

How do friends and neighbors respond?

STRENGTHS / SUPPORTS

Please list a number of things your child enjoys doing:

1.

2.

Please list some positive things about your child (examples: athletic, can be a good helper at times, good sense of humor, intelligent, inquisitive, friendly...)

1.

2.

Please list some family strengths and supports (examples: extended family including grandparents, church family, family friends, Case manager, Counselor, Big Brother or Sister, Boy or Girl Scouts, other community agencies...)

- | | | |
|---|--|--|
| <input type="checkbox"/> Grandparents | <input type="checkbox"/> Counselor | <input type="checkbox"/> Dance classes |
| <input type="checkbox"/> Aunts/Uncles/cousins | <input type="checkbox"/> Sports | <input type="checkbox"/> Case manager |
| <input type="checkbox"/> Church family | <input type="checkbox"/> Big Brother or Sister | |
| <input type="checkbox"/> family friends | <input type="checkbox"/> Boy or Girl Scouts | |

Other community agencies (Please list)

Thank you in advance for completing the intake form.

Signature of person completing the form: _____

Relationship to child: _____