WASHINGTON HEALTH SYSTEM
Children's Therapy Center

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

__Defiance
__Back-talk
__Verbal Aggression
__Attention problems
__Hyperactivity
__Difficult community behavior
__Ignoring of direction
__Physical aggression
__Destruction of property
__Impulsivity
__Deficient grooming and hygiene
__ Tough time doing homework
__ Tantrums

Emotional Problems

__Appears depressed
__Irritability
__Obsessive thoughts
__Sleep problems
__ Self-Injurious behavior
__Anxiety
__Compulsions (doing things over and over)
__Low self-esteem
__Talk of wanting hurt self or not be alive
__Psychiatric hospitalization

Social Problems

__ Difficulty establishing friendships
__ Difficulty maintaining friendships
__Arguments with peers
__Physical confrontations with peers
__Alienated by peers
__Withdraws from peers
__Social phobia (extreme fear of social situations)

School problems

__ Underachievement
__ Behavior problems in school
__ After-School Detentions
__ Lunch/Recess Detentions
__ Problems reading
__ Problems writing
__ Does not turn-in homework
__ Does not bring homework home
__School refusal
__Suspensions
__Threat of expulsion
__Poor grades
__ Problems with math
__ Leaves homework at home
__ Being bullied

Food Issues

__Lack of appetite
__Over-eating
__Bingeing (eating large amts of food all at once)
__Purging
__Low calorie intake
___ Finicky
___ Excessive time to eat meals
___ Putting too much food in mouth at once
___ Choking/Gagging
___ Can't sit through a meal
___ Uses eating utensils

Delinquency

__Problems with the police
__Alcohol use
__Cigarette use
__ Probation
__Running away from home
__Marijuana use
__ Stealing from home/community (stores)

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…)

___ Grandparents
___ Aunts/Uncles/cousins
___ Church family
___ family friends
___ Counselor
___ Sports
___ Big Brother or Sister
___ Boy or Girl Scouts
___ Dance classes
___ Case manager

___ Other community agencies (Please list)
____
____

Thank you in advance for completing the intake form.

Signature of person completing the form: ________________________________

Relationship to child: ________________________________