WASHINGTON HEALTH SYSTEM

Children's Therapy Center
1000 Waterdam Plaza Drive, Suite 120 McMurray, PA 15317 724-942-6100

Client Information

Child's Name: _____

Date of Birth: _____

Age: _____ _____ Male_____ Female

Eye Color _____ Ethnicity: _____

Height (if known): _____ Weight (if known): _____

Address: _____

_____

County: _____

Home Phone Number: _____

Alternative (cell) # _____

Email Address (parent): _____

Neighborhood environment: rural / suburban / city / safe / unsafe /

Insurance: Primary _____ ID # _____

Grp # _____

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

Secondary Insurance (Medical Assistance) _____ 10 Digit #_____

Family Information

Biological Mother's Name: _____ Age: _____

Place of Residence (if different):_____

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

Stepparent name (if applicable) _____

Biological Father's Name: _____ Age: _____

Place of Residence (if different):_____

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 and age:

_____
_____
_____

<u>School Information</u>

School: _____
School District: _____
Grade: _____
Special Education: _____ No ___ Yes: Type:Learning Support / Autism
Emotional Support / Other

<u>Health / Medication / Mental Health</u>

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

<u>Current Medications</u>:

Name	Dose
_____	_____
_____	_____

Past Medications:

Name	Reason discontinued
_____	_____
_____	_____
_____	_____

Who prescribes the medication:_____

Child's Pediatrician: _____

Pediatricians Phone # _____ Month/Year of Last Visit _____

Medical Conditions

Allergies	___ No	___ Yes: Type-
Asthma	___ No	___ Yes
Seizures	___ No	___ Yes
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?
Yes / No
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)?

_____

CONCERNS (Please check-mark those that apply)

Family Instability / Trauma / Abuse

__Physical Abuse
__Witness of domestic violence
__Foster care
__Neglect
__Parent Incarceration
___ Sexual Abuse
___ Witness of parental substance abuse
___ Out of home placement
___ Children-Youth services involvement

Signs of Autism

__ 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
__Ignoring of direction
__Physical aggression
__Destruction of property
__Impulsivity

__Hyperactivity
__Difficult community behavior
__ Tantrums
__Deficient grooming and hygiene
__ Tough time doing homework

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 at once food all at once)
__Purging
__Low calorie intake
___ Finicky
___ Excessive time to eat meals
___ Putting too much food in mouth
___ Choking/Gagging
___ Can't sit through a meal

Delinquency

__Problems with the police
__Running away from home

__Alcohol use
__Cigarette use
__ Probation
__Marijuana use
__ Stealing from home/community (stores)

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?

Please describe any ***family history of behavioral health*** issues (either side of the family including mother, father, brother(s), sister(s), grandparents, aunts, uncles, cousins…?

STRENGTHS / SUPPORTS

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

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

Strengths and Resiliency Inventory: SEARS

Please complete this section if your child is age 3 to 6 years of age

	Never	Sometimes	Often	Always
Wants to be a helper around the house.....	0	1	2	3
Has an interest in other kids and wants to be around them	0	1	2	3
Will approach and play with other kids.....	0	1	2	3
Other kids seem to think he/she is fun to be around.....	0	1	2	3
Seems to understand the feelings of others.....	0	1	2	3
Seems to care if he hurts somebody else's feelings.....	0	1	2	3
Solves simple problems to make the situation better.....	0	1	2	3
Is able to admit wrong-doing (to at least some extent).....	0	1	2	3
Is able to calm down quickly after becoming upset.....	0	1	2	3
Is able to accept reasoning to calm-down.....	0	1	2	3

Please complete this section if your child is age 7 through Teenage years:

	NEVER	SOMETIMES	OFTEN	ALWAYS
Tries to help others when they need help.....	0	1	2	3
Makes friends easily.....	0	1	2	3
Other kids ask him/her to hang out with them.....	0	1	2	3
People think she/he is fun to be with.....	0	1	2	3
Understands how other people feel.....	0	1	2	3
Cares what happens to other people.....	0	1	2	3
Thinks of her/his problems in ways that help.....	0	1	2	3
Accepts responsibility when she/he needs to.....	0	1	2	3
Is able to handle problems on her/his own.....	0	1	2	3
Knows how to calm down when stressed or upset.....	0	1	2	3
Knows how to identify and change negative thoughts.....	0	1	2	3
Can identify errors in the way he/she thinks about things.....	0	1	2	3

Behavioral Assessment - Progress Tracker (BA-PT)

Please *circle the number* to indicate the extent of difficulty in each area:

Your child's mood

Happy.....Neutral.....Irritable/Depressed

1 2 3 4 5 6 7 8 9 10

Anger / Outbursts

Stable.....Some outbursts.....Explosive

1 2 3 4 5 6 7 8 9 10

Following Directions / Defiance

Complies... Ignores... Put's it off but does it... Oppositional (some back-talk)... Outright Defiant

1 2 3 4 5 6 7 8 9 10

Response to Discipline (such as being sent to time-out or loss of video-game)

Accepts the punishment without problem.....Whines.....Cries.....Yells.....Hits, Kicks

1 2 3 4 5 6 7 8 9 10

Attention to Task

Good Attention.....Completes short tasks.....Needs "constant prompting

1 2 3 4 5 6 7 8 9 10

Activity Level / Hyperactive

Able to remain focused.....Fidgety.....Can't sit still

1 2 3 4 5 6 7 8 9 10

Ability to Occupy Free-Time Appropriately

Able to occupy time without problem.....Always into mischief - have to watch very closely

1 2 3 4 5 6 7 8 9 10

Sleep and Bedtime Behavior

Sleeps well..... Up a few times.....Up throughout night or can't/won't fall asleep

1 2 3 4 5 6 7 8 9 10

Appetite and Mealtime behavior

Eat well .....Finicky but eats relatively well.....Won't eat or very finicky

1 2 3 4 5 6 7 8 9 10

Grooming/Hygiene and Morning/Bedtime Routine

No Problem.....Will bathe if prompted.....Refuses to bathe or doesn't care

1 2 3 4 5 6 7 8 9 10

Friendships / Socialization

No Problem.....Some friends (only a few and has difficulties with this).....No Friends

1 2 3 4 5 6 7 8 9 10

Sibling Relationship

Generally get along.....Bicker a lot.....Fight a lot and Physically Aggressive

1 2 3 4 5 6 7 8 9 10

Community Behavior

Generally okay.....Some Problems.....All over the place and tantrums

1 2 3 4 5 6 7 8 9 10

School Behavior/Functioning

Functions pretty well.....Some conflicts and Difficulties.....Fights and Suspensions

1 2 3 4 5 6 7 8 9 10

AUTISM

Self-Stimulatory Behavior

Rare.....Sometimes (easily redirected).....Frequent 'stims' (hand-flapping, rocking...)

1 2 3 4 5 6 7 8 9 10

Communication / Verbal Skills

Very Verbal.....Moderate Problems..... Very Limited (nonverbal or echo/script)

1 2 3 4 5 6 7 8 9 10

Obsessions

Not obsessive.....Moderate.....Severe (always talking about the same thing)

1 2 3 4 5 6 7 8 9 10

Sensory

No major problems.....Lots of Sensory issues (gets in the way of daily functioning)

1 2 3 4 5 6 7 8 9 10