EMERGE COUNSELING MINISTRIES
CHILD/ADOLESCENT PSYCHOSOCIAL ASSESSMENT

Date of appointment: _____ **Time of appointment: _____**

Client Name: _____ **Age: _____** **DOB: _____**

Gender: ☐ Male ☐ Female **Preferred Name/Nickname: _____**

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race: _____**

Cultural Background: _____

PRESENTING PROBLEM: (Briefly describe the issues/problems which led to your decision to seek therapy services).

_____

_____

_____

How severe, on a scale of 1-10 (with 1 being the most severe)**, do you rate your child's presenting problems?**

MOST SEVERE 1 2 3 4 5 6 7 8 9 10 LEAST SEVERE

PRESENTING PROBLEM CATEGORIZATION: (Please check all the apply and circle the description of symptom)

Symptoms causing concern, distress or impairment:

☐ **Change in sleep patterns** (*please circle*): sleeping more sleeping less difficulty falling asleep difficulty staying asleep difficulty waking up difficulty staying awake

☐ **Concentration:** Decreased concentration Increased or excessive concentration

☐ **Change in appetite:** Increased appetite Decreased appetite

☐ **Increased Anxiety** (describe): _____

☐ **Mood Swings** (describe): _____

☐ **Behavioral Problems/Changes** (describe): _____

_____

How long has this problem been causing your child distress? (please circle)

One week One month 1 – 6 Months 6 Months – 1 Year Longer than one year

How do you rate your child's current level of coping on a scale of 1 – 10 (with 1 being unable to cope)**?**

UNABLE TO COPE 1 2 3 4 5 6 7 8 9 10 ABLE TO COPE

FAMILY COMPOSITION:

Mother's Name: _____ Age: _____

☐ Living with child ☐ Not living with child Employed Currently? ☐ Yes ☐ No

Place of Employment: _____ Occupation: _____

Father's Name: _____ Age: _____

☐ Living with child ☐ Not living with child Employed Currently? ☐ Yes ☐ No

Place of Employment: _____ Occupation: _____

Marital status of Parents: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in- or outside the home. Please include all members currently residing in child's household.

Name	Gender	Age	Relationship To Client	Living With Child
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

What else do you feel/believe would be helpful, or important for us to know/understand about your relationships with your family or about your family members?

_____

_____

_____

RECENT LOSSES FOR THE FAMILY:

☐ Family Member ☐ Friend ☐ Health ☐ Lifestyle ☐ Job ☐ Income ☐ Housing ☐ None

Who? _____ When? _____ Nature of Loss? _____

Other Losses: _____

Additional information (if needed):

_____

_____

PREGNANCY & BIRTH HISTORY:

Were there any complications during pregnancy? ☐ Yes ☐ No If yes, please explain: _____

_____

☐ Full-term Birth ☐ Premature Birth

Were there any complications during birth? ☐ Yes ☐ No If yes, please explain: _____

_____

Were drugs or alcohol consumed during pregnancy? ☐ Yes ☐ No

Child's weight at birth? _____ lbs. _____ oz. **Child's health at birth?** _____

Length of hospital stay? _____ **Post-partum depression?** ☐ Yes ☐ No

Was your child adopted? ☐ Yes ☐ No If yes, at what age? _____

☐ Domestic adoption ☐ International adoption (Country: _____)

DEVELOPMENTAL HISTORY:

As accurately as you can remember, how old was your child when she/he:

Rolled over? _____ Crawled? _____ Walked? _____ Talked (two words)? _____ Toilet Trained? _____

Do/did you have concerns about your child's development in any of these areas (below)?

☐ Speech/Language ☐ Motor Skills ☐ Cognitive/Intellectual ☐ Sensory ☐ Behavioral ☐ Emotional ☐ Social

If so, please describe: _____

_____

Were there any significant disturbances/changes during your child's childhood? ☐ Yes ☐ No

If yes, please describe: _____

_____
_

HEALTH HISTORY

How would you describe your child's overall health? _____

Does your child have any health issues? ☐ Yes ☐ No If yes, please list below: _____

Primary Care Doctor: _____ **Facility:** _____
Phone Number: _____ **Date of last physical:**_____
_____

Does your child have any recurrent medical conditions such as ear infections, asthma or allergies? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have tubes in his/her ears? ☐ Yes ☐ No

Include current significant medical problems, physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc.

Medical Conditions	Currently receiving treatment?	Provider	Does this condition cause stress or impairment at this time?	What have you found that helps?

Does your child take any medications? Yes No

Please list medications (including psychotropic, over-the-counter, herbal remedies) that your child has taken in the past 6 months

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

Is your child taking the medications as prescribed? Yes No If No, please explain: _____

_____

Additional information (if needed): _____

Has your child ever had a serious accident/illness or hospitalization? Yes No

Please list all past hospitalizations, surgeries, accidents, concussions, or illnesses in the chart below.

Reason for Previous Hospitalizations, Accident, Illness	Date/Location of Hospitalization

Has your child had the following screenings (please check all that apply)?

☐ Hearing Screening Date: _____ Outcome: _____

☐ Vision Screening Date: _____ Outcome: _____

☐ Speech/Language Screening Date: _____ Outcome: _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Is your child currently being seen by a counselor? ☐ Yes ☐ No

If yes, name of current counselor _____ Length of Treatment _____

Is your child currently being seen by a psychiatrist? ☐ Yes ☐ No

If yes, name of current psychiatrist _____ Length of Treatment _____

Has your child ever been diagnosed with a mental health, emotional or psychological condition?

☐ Yes ☐ No

If yes, what diagnosis was your child given? _____

When? _____

By Whom? _____

Has your child received counseling services or been hospitalized for mental health or drug and alcohol concerns in the past? ☐ Yes ☐ No

If yes, please list previous counseling/hospitalizations for mental health/drug and alcohol concerns below

Dates of Service	Place/Provider	Reason for treatment	Were the services helpful

Additional information: _____

_____

SAFETY CONCERNS:

Is your child presently suicidal? ☐ Yes ☐ No If Yes, please explain _____

Has your child ever attempted to commit suicide? ☐ Yes ☐ No If yes, when and how? _____

_____

Is there a history of suicide in your child's immediate and/or extended family? ☐ Yes ☐ No

If Yes, please explain _____

_____

Has your child ever self-injured (i.e. cutting, burning or wounding his/herself)? ☐ Yes ☐ No

If Yes, please explain _____

_____

Is your child presently homicidal? ☐ Yes ☐ No If yes, please explain _____

_____

Additional Information: (please list additional information as needed to address past and current safety issues)

_____

_____

_____

CURRENT FUNCTIONING:

Do you have concerns about your child in the following areas? (check all that apply)**?**

☐ Eating ☐ Hygiene/grooming ☐ Sleeping ☐ Activities/play ☐ Social Relationships

If so, please describe: _____

_____

Please rate your child's personality/temperament (how they behave the majority of the time in each of the following areas on a scale from 1 to 7 by placing a check above the number that best describes your child):

ENERGY/ACTIVITY LEVEL (how active is my child?)

CAN sit still and listen for long periods of time ____: ____: ____: ____: ____: ____: ____ **CAN'T** sit still and listen for long periods of time

1 2 3 4 5 6 7

NEED FOR PHYSICAL ROUTINE (how much routine does my child need)?

ENJOYS ROUTINE; easily upset when day doesn't go as usual ____: ____: ____: ____: ____: ____: ____ 1 2 3 4 5 6 7 **ENJOYS DOING THINGS DIFFERENTLY**; may not notice small changes in the day

MOOD (what is my child's mood most of the time)?

ANXIOUS-usually frustrated and worried ____: ____: ____: ____: ____: ____: ____ 1 2 3 4 5 6 7 **CALM**-usually relaxed

HAPPY-usually enjoys what he/she is doing ____: ____: ____: ____: ____: ____: ____ 1 2 3 4 5 6 7 **SAD**-usually unhappy; hard time having fun

CURIOUS-usually eager to know something ____: ____: ____: ____: ____: ____: ____ 1 2 3 4 5 6 7 **TIMID**-usually not interested

ANGRY-easily frustrated and annoyed with others ____: ____: ____: ____: ____: ____: ____ 1 2 3 4 5 6 7 **CALM**-usually composed and peaceful with others

INTENSITY (how strongly does my child express feelings, wants and opinions?)

MILD REACTION-calm and cooperative; Easily pushed around by others ____: ____: ____: ____: ____: ____: ____ 1 2 3 4 5 6 7 **STRONG REACTION-** may cry or yell over small things

PERSISTENCE (Can my child stick with and complete tasks?)

Will stick with something until it is done ____: ____: ____: ____: ____: ____: ____ 1 2 3 4 5 6 7 **Gives up on tasks**; has trouble finishing things

SENSITIVITY TO SENSES (How sensitive is my child to light, smells, sounds, and touching?)

Learns by seeing touching and using all his/her senses ____: ____: ____: ____: ____: ____: ____ 1 2 3 4 5 6 7 **Has strong reaction** to noise, lights, hugging or touching

PERCEPTIVENESS (How aware is my child of feelings and emotions?)

Sympathetic to others; **Unaware** of the

can use words to tell he/she feels ____: ____: ____: ____: ____: ____: ____ feelings of others how
1 2 3 4 5 6 7

ADAPTABILITY (How easily does my child accept changes?)

Often fearful with new people and new situations ____: ____: ____: ____: ____: ____: ____ **Will easily meet** and accept new people and activities
1 2 3 4 5 6 7

ATTENTION SPAN/DISCTRACTIBILITY (How well does my child pay attention?)

Stays focused on tasks until completed ____: ____: ____: ____: ____: ____: ____ **Easily sidetracked**; difficulty following directions
1 2 3 4 5 6 7

PARENT/CHILD RELATIONSHIP

Describe parenting your child (e.g. challenging, easy): _____

What do you find most challenging in parenting your child? _____

What kind of discipline works best with your child? _____

EDUCATION

Is your child currently enrolled in school? ☐ Yes ☐ No **Name of School** _____

What grade is your child currently in (if summer, was grade is your child going into)? _____

How would you describe your child's attendance (currently)? (circle ALL that apply)

Attending regularly Home-schooled Some truancy Alternative school Suspended
Expelled Dropped Out GED program

How would you describe your child's achievement/grades in school? _____

How would you describe your child's attitude towards school/education? _____

Disciplinary or behavioral issues at school? ☐ Yes ☐ No **If yes, describe: _____**

_____

_____

Please check if your child has any of the following?

☐ **Special Education Accommodations or a 504? Please describe:**
_____

☐ **An Individualized Education Plan (IEP)? Please describe:**
_____

☐ **Diagnosed Learning Disability? Please describe:**
_____

☐ **Receiving special services at school? Please describe:**
_____

FAMILY SPIRITUAL HISTORY:

Attend Church? ☐ Yes ☐ No **If yes, denomination?** _____

Attitude of client toward church? _____

Attitude of client toward God? _____

Attitude of family toward God/church?_____

EMPLOYMENT:

Is your child currently employed? ☐ Yes ☐ No

If employed, where are they working? _____ **How long?** _____

Does your child enjoy their current job? ☐ Yes ☐ No

HOUSING:

Would you consider your housing to be: ☐ **stable** ☐ **unstable** **If unstable, please describe: _____**

_____

Please choose the one that best describes the current housing arrangement for this child:

☐ Parent/Guardian owns home ☐ Parent/Guardian rents home
☐ Child and family live with relatives/friends (temporary)
☐ Child and family live with relatives/friends (permanent)
☐ Homeless ☐ Transitional Housing ☐ Emergency Shelter

How long has this child lived in the current living situation? _____

How many times has the child moved in the past two years? _____

What else do you think is important for us to understand about your housing/living situation?

_____

FOSTER CARE INVOLVEMENT:

Has your child ever been in foster care? ☐ Yes ☐ No ☐ Unknown

From _____ age to _____ age Reason: _____

Type of Placement: ☐ Familial Placement ☐ Non-Familial Placement
Current Status: ☐ In-Care ☐ Out of Care
If Out of Care, reason for leaving: ☐ Adopted ☐ Returned to Home ☐ Emancipated
☐ Ran away from care ☐ Other: _____

FAMILY MENTAL HEALTH HISTORY

Please identify if any members of your family have had a history of any of the following mental health/drug abuse/legal concerns.

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Child										
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										
Paternal Aunt										
Maternal Grandmother										

Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Biological Child										

Additional Information: _____

_____

_____

ALCOHOL/DRUG ASSESSMENT:

Does your child use tobacco or smokeless tobacco or vaping products? Yes No Do not know

Does your child use alcohol or drugs? Yes No Do not know

If yes, please explain_____

To your knowledge, has your child ever used medications (prescriptions drugs or over the counter medication) recreationally? Yes No Do not know

To your knowledge, has your child ever overdosed or passed out on alcohol or other drugs?

Yes No If yes, when was the last overdose? _____

LEGAL INVOLVEMENT:

Is there a current custody case involving your child? Yes No If yes, please describe below.

History of Child Protective Services involvement: None Past Current Please describe below.

Please indicate by checking your child's legal status below.

No Involvement Probation | Length: _____

Parole | Length: _____ Charges Pending Prior Incarceration

Law Suit or other Court Proceeding

Charges: _____ Probation/Parole Officer's Name: _____

Contact #:_____

Additional Information: _____

_____

HISTORY OF ABUSE/NEGLECT/VICTIMIZATION:

Has your child ever been abused or assaulted? ☐ Yes ☐ No If Yes, please complete the chart below.

Type of Abuse	By Whom? (relation to child if any)	At What Age?	Was it Reported?
☐ Sexual			☐ Yes ☐ No
☐ Physical			☐ Yes ☐ No
☐ Emotional			☐ Yes ☐ No
☐ Verbal			☐ Yes ☐ No
☐ Abandoned/Neglected			☐ Yes ☐ No
☐ Robbery Victim			☐ Yes ☐ No
☐ Assault Victim			☐ Yes ☐ No
☐ Domestic Violence			☐ Yes ☐ No
☐ Human trafficking			☐ Yes ☐ No
☐ Auto accident			☐ Yes ☐ No
☐ Other			☐ Yes ☐ No

Has your child ever been a victim of bullying? ☐ Yes ☐ No

Do you worry about your child's safety now? ☐ Yes ☐ No

What else do you feel is important for us to know? _____

_____

_____

HISTORY OF VIOLENCE:

Has your child ever been accused of abusing or assaulting someone? ☐ Yes ☐ No If yes, please complete chart below.

Type of Abuse	To Whom?	Age of your child?	Was it Reported?
☐ Sexual			☐ Yes ☐ No
☐ Physical			☐ Yes ☐ No
☐ Emotional			☐ Yes ☐ No
☐ Verbal			☐ Yes ☐ No

☐ Abandoned/Neglected			☐ Yes ☐ No

Has your child ever been known to bully other children? ☐ Yes ☐ No

What else do you feel/believe is important for us to know? _____

_____

STRENGTHS/RESOURCES/SUPPORTS:

What strengths does your child/ family have?_____

_____

What limitations does your child/family have? _____

_____

What resources does your child have to help with your current problem?

_____

What experiences (past & present) will help you in improving the current situation?

_____

_____

What are you (and your family) already doing to improve the current situation?

_____

Who does/can your child count on for support? ☐ Parents ☐ Boyfriend/Girlfriend ☐ Siblings ☐ Extended Family ☐ Friends ☐ Neighbors ☐ School Staff ☐ Church ☐ Pastor ☐ Therapist ☐ Group ☐ Community Services ☐ Doctor ☐ Other:

_____

CURRENT NEEDS/GOALS

What do you feel is your child's biggest need right now? _____

What do you most hope to gain from coming to counseling? _____

If you were to pick three goals that you believe could help your child work on his/her issues, what would they be?

Goal 1: _____

Goal 2: _____

Goal 3: _____

What else would you like for us to be aware of?

_____

_____

_____

DATE FORM COMPLETED: ____/____/____

INDIVIDUAL(S) COMPLETING THIS FORM:

Please check all that apply

Relationship	Printed Name	Signature
☐ Parent/Legal Guardian		
☐ Family Member		
☐ Friend		
☐ Foster Parent		
☐ Social Worker		
☐ Translator		
☐ Other		