CLIENT PSYCHOSOCIAL ASSESSMENT

The following necessary information will help make your first session most productive. Signed consent is required from the parent(s) or legal guardian before treatment can be provided. If you are court-mandated to receive counseling, bring in the court order or case plan. Please bring all documents to the *FIRST* session.
Please **PRINT** and fill out this form **COMPLETELY**.

Date of Assessment: _____

DEMOGRAPHICS

Who is providing information for this assessment?

☐ **Child / Adolescent** ☐ **Self** ☐ **Parent / Guardian / Representative:** _____
FULL NAME RELATIONSHIP

_____ _____ _____
Last Name **First Name** **Middle Name**

_____ _____ _____
Date of Birth **Age** **Parent / Guardian Name(s)**

_____ _____ _____ _____
Residence Address **City** **State** **Zip Code**

_____ _____
Telephone (Cell) **(Home)** **(Work)** **Adult / Parent Email Address**

PERSONAL HISTORY

Why are you seeking therapy at this time?

_____

_____

What has been done so far to address these concerns?

_____

_____

What area(s) do you / or your child need help? (CHECK PLEASE)

☐ **ANXIETY**	☐ **ADHD**	☐ **SUBSTANCE ABUSE**
☐ **DEPRESSION**	☐ **ACADEMIC PROBLEMS**	☐ **HOUSING**
☐ **ANGER MANAGEMENT**	☐ **MOOD SWINGS**	☐ **LEGAL / JUVENILE JUSTICE**
☐ **BEHAVIOR**	☐ **GRIEF/DEATH/LOSS**	☐ **TRAUMA / ABUSE**
☐ **FAMILY CONFLICT**	☐ **SIGNIFICAN RELATIONSHIP**	☐ **EMPLOYMENT / WORK**

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Has your child had any of the following within the past 90 days? (CHECK PLEASE)

☐ SUICIDAL THOUGHTS	☐ DEPRESSION	☐ FIRE SETTING
☐ SUICIDE ATTEMPTS	☐ AGITATION / IRRITABILITY	☐ CRUELTY TO ANIMALS
☐ SELF INJURY	☐ ANXIETY / PANIC / FEAR	☐ POOR SLEEP PATTERNS
☐ RACING THOUGHTS	☐ WEIGHT GAIN / LOSS	☐ PARANOIA / DELUSIONS
☐ THOUGHTS OF HARM (OTHERS)	☐ HYPERACTIVITY	☐ FOCUS / ATTENTION
☐ VOILENCE	☐ HALLUCINATIONS (VOICES/VISIONS)	
☐ MOOD SWINGS	☐ OBSESSIVE / INTRUSIVE THOUGHTS	

Has your child ever been in counseling before? ☐ YES ☐ NO
(IF YES PLEASE COMPLETE BELOW)

_____ _____ _____
DATES COUNSELOR REASON FOR DISCONTINUING / DISCHARGE

Starting with most current, please list current and past mental / behavioral health medications:

MEDICATION	DOSE	REASON	DOCTOR	STILL TAKING?

Any hospitalizations / mental / behavioral reasons? ☐ YES ☐ NO
(IF YES PLEASE COMPLETE BELOW)

_____ _____ _____
DATES LOCATION DOCTOR

Is there any family history of mental health problems or suicide (attempts)? ☐ YES ☐ NO
(IF YES PLEASE EXPLAIN BELOW)

_____

_____

MEDICAL

Who is your primary care physician?

_____ _____ _____
DOCTOR ADDRESS / LOCATION PH. NUMBER

VOCATIONAL / EDUCATION

_____ _____ ☐ REGULAR ☐ ESE ☐ GIFTED
SCHOOL GRADE

CLIENT PSYCHOSOCIAL ASSESSMENT

Please indicate any aggravating behaviors or circumstances: (CHECK ALL THAT APPLY)

☐ POOR PERFORMANCE	☐ REPEATED GRADE	☐ SUSPENDED
☐ SOCIAL PROBLEMS	☐ TARDY / SKIPPING CLASS	☐ EXPELLED
☐ DISRUPTIVE / DEFIANT	☐ EXCESSIVE ABENCES	☐ DROPPED OUT

LEGAL

Has your child / adol been arrested in the past two years?	☐ YES	☐ NO
Are you involved with DCF / FFN case or investigation?	☐ YES	☐ NO
Are you court ordered for services?	☐ YES	☐ NO
Are you currently assigned to a probations officer or caseworker? (IF YES PLEASE EXPLAIN BELOW)	☐ YES	☐ NO

AGENCY _____ NAME _____ PHONE _____

SUBSTANCE USE

Is your child / adol using any drugs or alcohol?	☐ YES	☐ NO
Have you used or are currently using any drugs or alcohol?	☐ YES	☐ NO

Explain any further history of substance abuse:

_____

_____

RECOVERY ENVIROMENT

What are your child / adol interest?

_____

_____

Are there any activities (e.g. sports, religion) that your child can participate in? ☐ YES ☐ NO

Describe your home environment:

_____

_____

FAMILY HISTORY

If parents are divorced, separated or never married, who has legal custody:

☐ Mother ☐ Father ☐ Shared / Joint

With whom does the child live: _____

Describe any other special arrangements: _____

NAME(S) OF SIBLING	BIRTH	GENDER	IF THEY ARE GOING TO PARTICIPATE IN COUNSELING
_____	_____	☐ M ☐ F	☐
_____	_____	☐ M ☐ F	☐
_____	_____	☐ M ☐ F	☐

CLIENT PSYCHOSOCIAL ASSESSMENT

_____ _____ ☐ M ☐ F ☐

Others living in the home:

RELATIONSHIP	AGE	GENDER	IF THEY ARE GOING TO PARTICIPATE IN COUNSELING
_____	_____	☐ M ☐ F	☐
_____	_____	☐ M ☐ F	☐
_____	_____	☐ M ☐ F	☐
_____	_____	☐ M ☐ F	☐

If you could change one thing about your family or your child, what would it be?

_____

_____

COMPLETED BY:

_____	_____	_____
PRINT NAME	**PRINT PARENT/GUARDIAN NAME**	**SIGNATURE**

STAFF ONLY

ENTERED BY: _____ **DATE:** _____