PAHRUMP VALLEY COUNSELING

3370 S. Highway 160, Suite 12
Pahrump, NV 89048
Office (775) 751-8980

CHILD/ADOLESCENT Initial Screening Form

Client Name:_____

Age:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female School Grade:_____

Cultural/Ethnic Background: ☐ African American/Black ☐ Caucasian/White ☐ Native American/First Nation ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic ☐ Other_____

Current Address:_____ City:_____ State:_____ Zip:_____

Home Telephone:_____ Alternate Telephone:_____

Current School:_____ Special Education: ☐ Yes ☐ No

Child Lives With: ☐ Parent(s) ☐ Foster Parent(s) ☐ Other Household Member(s) ☐ Other Relative(s) ☐ Other

Is the child adopted? ☐ Yes ☐ No

Custody Arrangements: ☐ Biological Parent(s) ☐ Biological Mother ☐ Biological Father ☐ Adoptive Parent(s) ☐ Friend ☐ Granparent(s) ☐ Foster Parent(s) ☐ Other Relative ☐ Juvenile Justice ☐ Ward of County/State ☐ Sibling ☐ Other:_____

Parent/Guardian #1:_____
Parent/Guardian #1 Primary Language:_____ SSN:_____
Parent/Guardian #1 Current Addess (If different):_____
City:_____ State:_____ Zip Code:_____ Telephone:_____

Parent/Guardian #2:_____
Parent/Guardian #2 Primary Language:_____ SSN:_____
Parent/Guardian #2 Current Addess (If different):_____
City:_____ State:_____ Zip Code:_____ Telephone:_____

Other Significant Adults:_____

DCFS Caseworker's Name:_____ Telephone:_____

Emergency Contact Name:_____ Telephone:_____

Parent/Guardian Biographical Information

Mother

What is the highest grade in school that the youth's primary caregiver completed. (Required Information (K-11)_____

☐ HighSchool Diploma/GED ☐ Associate's ☐ Master's
☐ Some college-no degree ☐ Bachelor's ☐ Doctoral
☐ Professional School

Employed: ☐ Yes ☐ No Occupation:_____

Father

What is the highest grade in school that the youth's primary caregiver completed. (Required Information (K-11)_____

☐ HighSchool Diploma/GED ☐ Associate's ☐ Master's
☐ Some college-no degree ☐ Bachelor's ☐ Doctoral
☐ Professional School

Employed: ☐ Yes ☐ No Occupation:_____

We are asking the following questions to get an understanding of your child's physical and emotional health. This is critical in determining your child's needs. Please check all answers that apply.

1. What is your primary concerns leading to referral?

- ☐ Fire-setter
- ☐ Theft/stealing
- ☐ Verbal outbursts
- ☐ Suicide thoughts
- ☐ Suicide attempt(s)
- ☐ Sexual acting out
- ☐ Cruelty to animals
- ☐ Physical aggression
- ☐ Somatic complaints
- ☐ Sadness/depression
- ☐ Impulsive/hyperactive
- ☐ Threat of life of others
- ☐ Anxiety
- ☐ Self injury
- ☐ Police contact
- ☐ Been retained
- ☐ Property damage
- ☐ Speech problems
- ☐ Academic problems
- ☐ Special Education (IEP)
- ☐ Truancy or suspensions
- ☐ Alcohol/substance abuse
- ☐ Attention/focus problems
- ☐ Excessive non-compliance
- ☐ Runaway
- ☐ Self-stimulating
- ☐ Poor self-esteem
- ☐ Self-isolates/withdraws
- ☐ Difficulty falling asleep
- ☐ Social contact avoidance
- ☐ Nightmares/sleep terrors
- ☐ Overdependence on others
- ☐ A lot of self-consciousness
- ☐ Bizarre or unusual thoughts
- ☐ Eating or appetite problems
- ☐ Strange/odd behaviors
- ☐ Been victim of bullying
- ☐ Been a victim of a crime
- ☐ Poor peer/sibling interactions
- ☐ Wandering the house at night
- ☐ Failure to respond to discipline
- ☐ Tension and difficulty relaxing
- ☐ Difficulty with waking up during night
- ☐ Excessive need for reassurance from others
- ☐ Heard voices talking to him/her (hallucinations)
- ☐ Incontinence or inappropriate bowel movements
- ☐ Other:_____

2. Has your child ever made any suicide attempt?

☐No ☐Yes If so, age(s)_____

3. Does your child have access to medications?

☐No ☐Yes Please explain_____

4. Has your child had any of the following medical conditions in the past year?

- ☐ Asthma
- ☐ Allergies
- ☐ Nose bleeds
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Ear infections
- ☐ Constipation
- ☐ Diabetes
- ☐ Tonsillitis
- ☐ Hives/eczema
- ☐ Overweight
- ☐ Underweight
- ☐ Bladder difficulties
- ☐ Inappropriate bowel movement
- ☐ Rheumatic fever
- ☐ Dizzy spells
- ☐ Sleep disorder
- ☐ Seizures
- ☐ Arthritis
- ☐ Bronchitis
- ☐ Cancer
- ☐ High fever/convulsions
- ☐ Frequent vomiting
- ☐ Frequent headaches
- ☐ Fainting/ blackouts
- ☐ High blood pressure
- ☐ Heart murmur/ problems
- ☐ Mental illness
- ☐ Other (specify): _____

5. Is your child currently taking any medications? ☐No ☐Yes

(If yes, fill in below; please attach a separate list if more space is needed.)

Primary Care Physician:_____ Psychiatrist:_____

Medications/Dosage/Frequency	Condition	Prescribing Physician

6. Is your child allergic to anything (including medications)? ☐No ☐Yes ***(If yes fill in below.)***

7. Stress situations that have been present <u>in the past year</u>?

- ☐ Death
- ☐ Divorce/separation
- ☐ Custody problems
- ☐ Financial hardship
- ☐ Remarriage
- ☐ Visitation
- ☐ Family violence
- ☐ Frequent arguments
- ☐ Parent/caregiver job change(s)
- ☐ Family member illness/accident
- ☐ High frequency moving
- ☐ Client changed schools
- ☐ Other: _____

8. Has your child had any of the following legal actions?

- ☐ Unknown
- ☐ Been on probation
- ☐ Been detained or arrested
- ☐ Been remanded to Detention Center or County/State Training Schools
- ☐ DCFS/CPS involvement

9. **Has your child received sexual education?** ☐Unknown ☐Yes ☐No

10. **Is your child or has your child been sexually active?** ☐Unknown ☐Yes ☐No

11. **Has your child ever engaged in any inappropriate sexual behavior?** ☐Unknown ☐Yes ☐No

12. **Physical/ Mental Health/ Educational Services**

Previous Treatment:	**If yes, where, when, reason (if applicable)?**
☐ Outpatient mental health services	_____
☐ Psychiatric evaluation/ medication management	_____
☐ Inpatient psychiatric hospitalization or crisis center	_____
☐ Mental health residential treatment	_____
☐ Alcohol or substance abuse treatment	_____
☐ Foster care or group home	_____
☐ Special education	_____
☐ Medical hospitalizations	_____

Prenatal/ Neonatal (*Birth/Infancy*) History (Please answer the best to your ability)

1. **Birth mother (check all that apply)**
   - ☐Unknown
   - ☐Smoked during pregnancy
   - ☐Have Rh factor incompatibility
   - ☐Used drugs during or before pregnancy
   - ☐Bled during the pregnancy
   - ☐Used alcohol during pregnancy
   - ☐Have medical or emotional problems during pregnancy

2. **Were there any known complications prior to and at birth? If so, please describe:**

Early Childhood History *(0-3 Years)* (Please answer the best to your ability)

1. **Was your child hospitalized? If yes:**
   - Age___ Reason_____
   - Age___ Reason_____
   - Age___ Reason_____
   - Age___ Reason_____
2. **Did your child sustain any significant head injuries? If yes, please describe:**

3. **Did or does your child have (check all that apply):**
   - ☐Unknown
   - ☐Speech disturbances
   - ☐Hearing problems
   - ☐Arching/stiffening when held
   - ☐Hyperactivity
   - ☐Clumsiness
   - ☐Vision problems
   - ☐Difficulty being consoled
   - ☐Special Education
   - ☐Act as if difficulty understanding spoken language
   - ☐Development delays? If yes, describe:

4. **Were there serious marital/ couple/ family problems during this period?** ☐Unknown ☐Yes ☐No

Preschool/ Childhood History/ Adolescent History (*3-17 Years*) (Please answer the best to your ability)

1. 1. Was your child hospitalized? If yes:

Age___ Reason_____
Age___ Reason_____
Age___ Reason_____
Age___ Reason_____
Age___ Reason_____

2. Did your child have any medical conditions? If yes, please describe:

3. Has your child been (check all that apply):

- ☐ Overly aggressive
- ☐ Accident prone
- ☐ Inattentive
- ☐ Clumsy
- ☐ Hard to discipline
- ☐ Withdrawn
- ☐ Unhappy
- ☐ Other _____
- ☐ Anxious
- ☐ Affectionate
- ☐ Serious marital/couple/family problems
- ☐ Special Education (IEP)
- ☐ Speech problems
- ☐ Victim of bullying
- ☐ Been retained
- ☐ Peer/sibling problems
- ☐ Problems with authority
- ☐ Substance abuse
- ☐ Sexual acting out
- ☐ Problems with the law

4. Were there serious marital/ couple/ family problems during this period? ☐ Unknown ☐ Yes ☐ No

5. Is there a family history of the following?

	Mothers' Side	Fathers' Side
Manic depression/Bipolar	☐	☐
Depression	☐	☐
Suicide	☐	☐
Drug abuse	☐	☐
Alcohol abuse	☐	☐
Developmental delay	☐	☐
Psychosis	☐	☐
Sexual abuse	☐	☐
Anxiety	☐	☐
Other:_____	☐	☐

	Mothers' Side	Fathers' Side
Physical abuse	☐	☐
Hyperactivity	☐	☐
Psychiatric medication	☐	☐
Obsessive Compulsive Disorder	☐	☐
Panic disorder	☐	☐
Gambling	☐	☐
Convicted of crime	☐	☐
Prison term	☐	☐
Hospitalization for mental illness	☐	☐

_____ _____
Signature Parent/ Legal Custodian Date