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Comprehensive Diagnostic Assessment (Minor)

Name: _____ DOB_____
Email: _____ Phone: _____

Clinician: _____ Date of Assessment: _____

Person providing this information: _____
Relationship to Child: _____

Primary Care Physician: _____
Psychiatrist: _____

Do you give permission for ongoing regular updates to be provided to your primary care physician and/or psychiatrist? Yes No

Please indicate the main reasons for seeking consultation and/or treatment or what are the presenting mental health concerns?

_____
_____
_____
_____
_____
_____

Prior Psychiatrist History/Diagnosis: _____
_____
_____

What are your treatment goals for your child?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed Mood	( ) Fatigue	( ) Excessive Energy
( ) Increased Irritability	( ) Oppositional Behavior	( ) Self-Esteem Issues
( ) Sleep Disturbances	( ) Racing Thoughts	( ) Crying Spells

( ) Loss of Interest
( ) Attention/Concentration
( ) Eating Disturbances
( ) Excessive Guilt/Shame
( ) Suicidal Thoughts
( ) Dissociation
( ) Chronic Pain
( ) Aggressive Behavior
( ) Other _____

( ) Impulsivity
( ) Increase Risky Behavior
( ) Distracted Easily
( ) Recent Changes
( ) Obsessive/Compulsive
( ) Temper/Anger Issues
( ) Flashbacks
( ) Attachment Difficulties

( ) Excessive Worry
( ) Anxiety Attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Self-Harm
( ) Hygiene Concerns
( ) Regressive Behavior

Current Family Situation

Place of birth/city/state: _____
Ethnicity: _____ Language: _____

Was your child adopted? _____ Yes _____No Age at adoption _____

Circumstances of Adoption
_____

Parents at the time of birth were: Married Separated Unmarried
If divorced, at what age was child at time of divorce? _____

Current Relationship Status of Mother: _____
_____
Current Relationship Status of Father: _____
_____

Who does child currently reside with? _____

Is there a custody order in place? _____
Please attach a copy of the most recent child custody order.

What is the custody arrangement? _____

Are there any current custody concerns/conflicts?

Father_____
Deceased, year _____
What is her level of education? _____
Occupation? _____

Please describe child's relationship with his/her father:
_____
_____
_____

Mother_____
Deceased, year _____
What is her level of education? _____
Occupation?_____

Please describe child's relationship with his/her mother:
_____
_____
_____

Please describe the current atmosphere of the marriage/ partnership in the home:
Please check all that apply:
____Good, satisfied ____Supportive ____Warm relationship ____Stable
____Bored ____Poor communication ___On the verge of break-up
____Abusive (physical, verbal, sexual)

Does the child witness frequent marital/partner conflicts:
_____

Has the child ever witnessed abuse within the marriage?
_____

Number of Siblings: _____
Full sisters _____Full brothers _____Half-sisters _____Half-brothers ____ Step-sisters
_____Step-brothers _____Deceased, age(s) at death _____

Please list all people in child's immediate family:

Name	Relationship to child	Age	Living in House?

Please list all other non-family members who live in household:

Name	Relationship to child/ family	Age	Length of time living in household

Does your child attend daycare? No_____ Yes _____ Please explain (where, how often) _____

Are there any other adults who have a significant role in raising your child?
No_____ Yes (please indicate name and relationship)
_____
_____

Have there been any significant changes in the home over the last few years? (For example, marriages, births, deaths, money problems, address changes, change religions etc.)
_____
_____
_____

Has your child ever witnessed an immediate family member become incarcerated? (If yes- please Explain- who, when, length of time, offense)
No_____
Yes_____
_____
_____

Are there are any concerns of physical abuse?
No _____ Yes (current) _____ Yes (in the past) _____ Unknown_____
If yes clarify when and by whom:
_____
_____

Are there are any concerns of emotional abuse?
No _____ Yes (current) _____ Yes (in the past) _____ Unknown_____
If yes clarify when and by whom:
_____
_____

Are there are any concerns of sexual abuse/ molestation/ and/ or sexual assault?
No _____ Yes (current) _____ Yes (in the past) _____ Unknown_____
If yes clarify when and by whom:
_____
_____

Are there are any concerns of neglect or the child's needs not being met?
No _____ Yes (current) _____ Yes (in the past) _____ Unknown_____
If yes clarify when and by whom:
_____
_____

Please explain your family's cultural and/or spiritual or religious background/ current practice:
_____
_____

How is your child disciplined in the home?
_____
_____

How does the family express and manage emotions in the home?
_____

What resources and supports do you and your family have?
_____
_____

What strengths does your child demonstrate in the family setting?
_____
_____

What are your child's hobbies, talents, or activities he/she most enjoys?
_____
_____

Family Psychiatric History

Please include any mental health and/or substance use problems with biological relatives. Consider diagnoses such as depression, anxiety, bipolar disorder, schizophrenia, ADHD, alcohol and/or drug abuse, incarceration, or any suicides.

Mother: _____
Mother's relatives:
_____
_____
Father:
_____
Father's relatives:
_____
_____
Siblings:
_____
_____
_____

Basic Living Skills History and Functioning

Please indicate your child's habits with the following basic living skills practices:

	Daily	A few times per week	Once per week or less
Bathing		_____	_____
Brushing teeth		_____	_____

Dress in clean/appropriate clothes _____ _____

Go to bed/wake up at regular times _____ _____

Preparing balanced meals _____ _____

Housekeeping activities _____ _____

Laundry _____ _____

Does your family regularly perform the following safety practices?

Lock door/secure home ___Yes ___No

Turn off the oven/running water, etc. ___Yes ___No

Is your family receiving personal care services, Meals on Wheels, or any other basic living skills provided? ___No ___Yes

Do you consent to allow your clinician to provide your child snacks, intermittently, as needed, to reinforce positive behavior or assist with improving their mood? _____

Does your child have reliable transportation, or do you have access to public transportation, etc?
_____Yes
No (please explain)_____

What supports and resources do you have in the community (churches, clubs, extra-curricular activities etc)?

_____

_____

Does your child have a: Social Security card _____Yes _____No
Driver's License _____Yes _____No

Medical History and Functioning:

How would you describe your child's overall health? _____
Medical doctor(s) / Specialists:

_____

_____

Date of Last Physical or Wellness Exam: _____

Mother's age at child's birth: _____ Did mother receive routine pregnancy care?
Yes _____ No _____

Please specify any medications used during mother's pregnancy:

_____

Pregnancy lasted _____ weeks/ months
Child's birth weight _____ pounds _____ounces

Please check the conditions below that describe the health of the child and mother during
Mother's Pregnancy
No complications _____ Blackouts_____ Falls _____ Physical Injury _____
Excessive Bleeding _____ Hypertension _____ Diabetes _____ Emotional
Stress _____ Depression _____ Anxiety _____ Abuse _____
Toxemia _____ Alcohol/ Drug Use _____ Tobacco Use _____

Delivery
Normal _____ Induced Labor _____ Forceps/ Vacuum Delivery _____
C-Section _____ Breech Birth_____ Unusually long labor
_____Premature (# of weeks) _____ Overdue (# of weeks)_____
Other_____

Child's Condition at Birth
Normal/ No complications _____ Lack of Oxygen _____ Breathing Problems
_____Heart problems _____ Birth injury/ defect _____ Jaundice
_____Newborn ICU (Length of stay) _____

Parent's Postpartum Period
Did mother experience postpartum depression after the birth?
No_____ Yes_____
Did mother experience postpartum anxiety after the birth?
No_____ Yes_____
Did father experience postpartum depression after the birth?
No_____ Yes_____
Did father experience postpartum anxiety after the birth?
No_____ Yes_____
Was there any increased marital tension after the birth?
No_____ Yes_____

Please circle any health conditions that apply for the child presently:
Thyroid problem High blood pressure Headaches Heart problems Sleep problems
High Cholesterol Asthma Trouble eating Stomach problems Seizures
Other (please describe):
_____

Has your child had any of the following?

	Yes/No	What	When
Contagious or Infectious Diseases			

_____
Disabilities or Handicaps
_____

Allergies/Food Allergies

_____

Has your child had any of the following?

	Yes / No	What	When
Accidents/injuries			
Surgeries			
Major illnesses			
Hospitalizations			
Loss of consciousness			

Medications- Please list all current prescribed or over the counter drugs / medications

_____No medications

Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____
Medication_____Dosage_____Doctor_____

****Please list additional medications on back of this page**

Can your child self-administer medications? _____Yes _____No

Medication Compliance:
____Regularly taken as prescribed
____Occasionally miss a dose
____Miss doses regularly
____Refuse/forgot to take meds most days

Has your child been treated in the past with psychiatric medications such as antidepressants, mood stabilizers, tranquilizers, sleeping aids, stimulants, or others? _____Yes _____No

Have any of your family members had significant illness or medical treatment? If so, please explain:

_____

Substance Use/Abuse

Do you have any concerns of substance use for your child? If yes, what substance and how often are they using?

Nicotine Use/Abuse

Sexual History or Concern

Does your child have any current or past age-inappropriate sexual behaviors? Sexually acting out? Or sexually aggressive behavior? If yes, please explain:

Behavioral Health Treatment History

	Service Provider	When / How often?	Was it helpful? Please explain
Counseling			
In-Patient Psych Center			
Case Management			
Medication Management			
CBRS / PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
Personal Care Services			
Home Health Provider			
Other			

Is there any history of the previous services received by immediate biological family members? If yes, please explain.

Developmental History

For the following developmental milestones please indicate the most appropriate response:

Milestone	Normal Age Range	Delayed but Caught Up	Ongoing/Current Concern
Sitting Up			
Crawling			
Walking			
Speaking first words			
Speaking sentences			
Fully Potty trained			
Stayed dry all night			

During your child's first few years of life, were any of the following significantly present?
Difficult to comfort _____Colicky _____Excessive Irritable _____
Diminished sleep _____Difficulty nursing _____
poor eye contact _____ did not respond to their name _____
fascination with certain objects _____constantly head banging_____

Prior to age 6 did your child have more difficulty than other children his/her age, (mark if yes):
Sitting still at mealtime _____paying attention when read to _____
throwing/catching a ball _____ buttoning or zipping _____ holding crayon or pencil _____accidently dropping/knocking thing over _____staying focused on tv, movies etc _____ waiting for turn at play _____ knowing left and right _____ dressing self _____tying shoe laces _____

If yes, please describe:

_____
_____
_____

How often are the following a problem for your child:

Getting ready for school:	Rarely ___	Sometimes _____	Frequently _____
Playing by him/herself:	Rarely ___	Sometimes _____	Frequently _____
With a babysitter/ at daycare:	Rarely ___	Sometimes _____	Frequently _____
In the car:	Rarely ___	Sometimes _____	Frequently _____
At school:	Rarely ___	Sometimes _____	Frequently _____
Playing by him/herself:	Rarely ___	Sometimes _____	Frequently _____

How would you describe your child's personality at home? _____
_____
How would you describe your child's personality at school? _____
_____

Are you interested in discussing parenting ideas/techniques as part of your child's therapy process? If yes, please describe areas of concern? _____
_____
_____
_____

Social History and Functioning

How would you describe your child's friendships – please circle all that apply-
No friends Only acquaintances Acquaintances and Friends

Please describe the following about your child in social settings:
Your child's temperament in social situations? (Shy. Outgoing, leader, follower)
_____
_____

How would you describe their behavior and comfort level when in social settings?
_____
_____

What are their talents and/or social strengths?
_____
_____

Do you have any concerns about your child's peer relationships, choice of friends and/or social functioning? If yes, please described: _____
_____

Does your child have appropriate social skills for their age/functioning? If no, please describe:
_____

Has your child ever complained of being bullied or been accused of bullying? If yes, please describe: _____
_____

Has your child identified a sexual orientation: _____
Gender identity: _____
Expressed any confusion/concern over either? _____

Do you have any concerns that your child is experiencing any difficulties with age, gender, sexual orientation, culture, race, or religion?
No____ Yes
_____
_____

Legal History and Functioning

Does your child have any current or past involvement with the legal system including diversion court, probation, arrest, illegal activity, or incarceration?
_____No _____Yes Please explain
_____
_____
_____
_____
_____

Vocational/Educational History and Functioning
Grade in School: _____ School: _____
Teacher_____
Child's Favorite Subject: _____

Please describe how your child did/does in elementary school:
Academically_____
Behaviorally_____
Socially_____

Please describe how your child did/does in junior high/high school:
Academically_____
Behaviorally_____
Socially_____

Does your child receive any specialized classroom setting or receive special education?
_____Yes_____No
Do they currently or in the past had an Individual Education Plan (IEP) or a 504plan:
_____
Has there ever been any concern expressed by physicians, teachers or other professionals related to your child meeting developmental milestones?
_____
Have there been any behavioral issues or concerns at school/ daycare, if yes, please describe:
_____

Does your child currently have educational goals? _____No _____Yes
_____

Has your child had any vocational training? _____No _____Yes
_____

Employment
Is your child currently employed? If yes please describe where and how long-
No _____ Yes_____

Does your child currently have employment goals? _____No _____Yes
_____

Financial History and Functioning

Are finances adequate to meet the family's needs ____Yes ____No – please explain:

_____

_____

Sources of Income: _____

Is there any parental stress of concern, if yes, please indicate:

_____

Housing History

Current Living arrangement:

___Own home
___Renting
___Living with friends/family
___Other
___Supported housing-explain_____

Does the current housing situation meet your child's needs in the following areas?

Health and safety ___Yes ____No-please explain_____
Access to services ___Yes ____No-please explain_____

Is there any history of homelessness/evictions? ____No ___Yes-please explain_____

Is there any risk of homelessness? ____No ____Yes-please explain_____

Signatures

Responsible party completing this form: _____
Relationship to Client: _____

Signature: _____
Date: _____