LIFE STRATEGIES COUNSELING CENTER LLC
16 N. CLYDE AVE
KISSIMMEE, FL 34741
407-738-0955

Date: _____

Child/ Adolescent Clinical Assessment

We would appreciate it if you would fill out this questionnaire. We realize that filling out these forms may prove somewhat burdensome. Nonetheless, they provide information that is crucial to our efforts to help your child/ adolescent. Also understand that this form is used with a wide variety of people and situations. All questions will not apply to your family; but all questions are important. Please answer as much as possible to the best of your ability. Your therapist with review the information with you so any questions you have will be covered in your first session. Thank you for entrusting us with such valuable information; we will always treat is as such.

DEMOGRAPHIC INFORMATION

Client's Information:

Name: _____ DOB: _____ Age: _____ Sex: M/F

Home Address:_____

_____

Mother's Information:

Name: _____ DOB:_____ Age_____

Highest Level of Education Completed? _____

Current Occupation: _____ Email: _____

Home Phone: _____ Cell: _____ Work: _____

Is it okay call you at: home? ☐ yes ☐no Work? ☐ yes ☐no
. Cell? ☐ yes ☐ no Is it Ok to text you? ☐ yes ☐no

Father's Information:

Name: _____ DOB: _____ Age: _____

Highest Level of Education Completed? _____

Current Occupation: _____ Email: _____

Home Phone: _____ Cell: _____ Work: _____

Is it okay call you at home? home? ☐ yes ☐no Work? ☐ yes ☐no
. Cell? ☐ yes ☐ Is it Ok to text you? ☐ yes ☐no

Does this child have additional parents/step-parents? ☐ yes ☐no

If yes, do they have permission to have information about this child/ adolescent? ☐ yes ☐no

Are there any other adults actively involved in this child/ adolescent's development? (ie nanny, grandparents, etc) If yes, please briefly explain the amount of time with person and the relationship.

_____

_____

If yes, please provide name, relationship, and contact number

_____

_____

_____

If yes, please give
Who lives in your household?

NAME	**AGE**	**RELATIONSHIP**
1.		
2.		
3.		
4.		
5.		
6.		

Past or Current Custody/Visitation/ Age of child (Explain):

_____

_____

_____

Reason for Referral:

Did someone refer you? ☐ yes ☐no If yes, who referred you and for what reason?

_____

_____

Why are you seeking counseling/assessment? _____

_____

_____

What do you hope to gain from counseling/assessment? _____

_____

_____

What is it about your child that stands out to you (child's strengths)?: _____

_____

_____

DEVELOPMENTAL HISTORY

Was your child adopted?	☐ yes ☐ no
If yes, at what age?	
Any birth complications?	☐ yes ☐ no
Did Your Child develop normally?	☐ yes ☐ no
Were either parent or the pediatrician concerned about any developmental progress?	☐ yes ☐ no
What age did this child learn to walk?	
Did this child have any difficulty learning to skip?	☐ yes ☐ no
What age did this child begin talking?	
What age did this child begin riding a bike without training wheels?	
Any hospitalizations?	☐ yes ☐ no
Childhood Illnesses?	
Has any member experienced Learning Disabilities, Attention Deficit Hyperactivity Disorder (ADHD), Anxiety, Depression, or any other behavioral health concern?:	☐ yes ☐ no
If yes, please list each person and their disability below:	
Any additional information we may need to know?	

EDUCATIONAL HISTORY

School:_____ County: _____ Grade: _____

Circle type of School Program: Home school Private School Public School

Is your child receiving any special services at school (tutoring, therapy, etc)? ☐ yes ☐no

Ever Repeat a grade? ☐ yes ☐no

If yes, what grade(s) and reason _____

Have any Testing or Evaluations been completed? ☐ yes ☐no

If yes, who completed the previous testing and when? _____

_____

Please bring in a copy of any previous testing completed

Please describe your teenager's last report card and/or any recent changes in grades:

_____

_____

Please describe any past school suspensions or expulsions: _____

_____

PEER RELATIONSHIPS

Does your child seek friendships with peers?	☐ yes ☐no
Is your child sought by peers for friendship?	☐ yes ☐no
Does your child play with children primarily his/her own age?	☐ yes ☐no
If not, does your child typical play with children older? Or younger?	
How does your child respond in a group setting?	☐ yes ☐no
Is your child cooperative with other children?	☐ yes ☐no
Is your child primarily a leader?	☐ yes ☐no
or a follower?	☐ yes ☐no
Is your child unaware or insensitive to the needs of others?	☐ yes ☐no
Does your child have difficulty in playing make believe or pretending?	☐ yes ☐no
Does your child have difficulty identifying when someone is teasing?	☐ yes ☐no
Does your child have difficulty understanding what causes other people to dislike him/her?	☐ yes ☐no
Can your child predict probable consequences in social events?	☐ yes ☐no

Describe briefly any problems your child may have with peers_____

_____

TEMPERAMENT

Activity Level: How active is your child? _____

Distractibility: How well does your child pay attention? _____

_____

Adaptability: How well does your child deal with transition and change? _____

_____

Approach/Withdrawal: How well does your child respond to new things? _____

_____

Intensity: Whether happy or unhappy, how aware are others of your child's feelings?

_____

Mood: What is your child's basic mood?_____

Regularity: How predictable are your child's patterns in sleep, appetite, etc. _____

Have the above behaviors been consistent throughout your child's life or have there been significant changes? Explain _____

How does your child cope with stressors? _____

_____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age? ☐ yes ☐no
How would you rate your child's overall level of intelligence compared to other children? Below Average Average Above Average
Does your child have difficulty understanding jokes/humor? ☐ yes ☐no
Does your child having difficulty understanding slang expressions? ☐ yes ☐no
Does your child ask for clarification when confused or switch to another topic? . ☐ yes ☐no

ADDITIONAL SYMPTOMATOLOGY

(Mark***/Check if applicable- give detailed explanation of occurrence)***

Behavior	**Explain if yes**

Difficulty focusing:	☐ yes ☐no	
Finger Nail Biting:	☐ yes ☐no	
Changes in Appetite:	☐ yes ☐no	
Changes in Toileting :	☐ yes ☐no	
Fear of Certain places/people/activities (phobias):	☐ yes ☐no	
Regression to earlier age behaviors (e.g. clingier	☐ yes ☐no	
Nightmares:	☐ yes ☐no	
Anxiety:	☐ yes ☐no	
Changes in Friendships:	☐ yes ☐no	
Hyperactivity:	☐ yes ☐no	
Episodes of crying:	☐ yes ☐no	
Sleep Problems:	☐ yes ☐no	
Changes in Appetite:	☐ yes ☐no	
Changes in Weight	☐ yes ☐no	
Takes Responsibility	☐ yes ☐no	
Difficulty with Stealing	☐ yes ☐no	
Difficulty with Lying	☐ yes ☐no	
Manipulative	☐ yes ☐no	
Other:	☐ yes ☐no	

SENSORY INFORMATION

Mark***/Check if applicable- give detailed explanation of occurrence***

Behavior		**Explain if yes**
Overly sensitive to touch	☐ yes ☐no	
Overly sensitive to movement/sights or sounds	☐ yes ☐no	

Picky Eater	☐ yes ☐no	
Complain about texture of food or clothing	☐ yes ☐no	
Over-react to ordinary activities, such as brushing teeth or bathing	☐ yes ☐no	
Fatigued easily	☐ yes ☐no	
Coordination problems	☐ yes ☐no	
Fine or gross motor skills	☐ yes ☐no	
Delayed in speech/language skills	☐ yes ☐no	
Constantly touching objects	☐ yes ☐no	
Distressed by socks seams	☐ yes ☐no	
Refuses to walk barefoot	☐ yes ☐no	
Sensitive to light	☐ yes ☐no	
Sensitive to loud noises	☐ yes ☐no	
Sensitive to smells	☐ yes ☐no	

GENERAL BEHAVIORS

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his/her own age.

Fidgets with hands, feet or squirms in seat	☐ yes ☐no
Has difficulty remaining seated when required to do so	☐ yes ☐no
Easily distracted by extraneous stimulation	☐ yes ☐no
Has difficulty awaiting his turn in certain situations	☐ yes ☐no
Blurts out answers to questions before they have been completed	☐ yes ☐no
Has problems following through with instructions	☐ yes ☐no
Has difficulty paying attention during tasks or play activities	☐ yes ☐no
Shifts from one uncompleted activity to another	☐ yes ☐no
Has difficulty playing quietly	☐ yes ☐no
Often talks excessively	☐ yes ☐no
Interrupts or intrudes on others	☐ yes ☐no
Does not appear to listen to what is being said	☐ yes ☐no
Loses things necessary for tasks or activities at home	☐ yes ☐no
Boundless energy and poor judgment	☐ yes ☐no

Impulsivity (poor self control)	☐ yes ☐ no
History of temper tantrums	☐ yes ☐ no
Temper outbursts	☐ yes ☐ no
Frustrates easily	☐ yes ☐ no
Inappropriate table manners	☐ yes ☐ no
Sudden outbursts in a physical manner of other children	☐ yes ☐ no
Acts like he/she is driven by a motor	☐ yes ☐ no
Wears out shoes more frequently than siblings	☐ yes ☐ no
Excessive number of accidents	☐ yes ☐ no
Doesn't seem to learn from experience	☐ yes ☐ no
Poor memory	☐ yes ☐ no
A "different child"	☐ yes ☐ no
Show an intense interest in a certain subject	☐ yes ☐ no
Sharp memory	☐ yes ☐ no
Concerns about dirt and germs	☐ yes ☐ no
Obsession over one's body	☐ yes ☐ no
Fear of losing something or throwing away something by mistake	☐ yes ☐ no
Concerns about neatness of personal appearance or environment	☐ yes ☐ no
Aligning objects so things will be "just so"	☐ yes ☐ no
Continuous counting	☐ yes ☐ no
Hair pulling	☐ yes ☐ no
Excessive hand washing	☐ yes ☐ no
Overly concerned over spiritual things	☐ yes ☐ no

How well does your child work for a short-term reward?

_____

How well does your child work for a long-term reward?

_____

Explain (if necessary) any of the above:

_____

RISK ASSESSMENT

To your knowledge has your child ever experienced the following;

	Past	Present	Comments
Suicidal thoughts/Gestures/Attempts	☐	☐	
Homicidal Ideation or Gestures	☐	☐	
Assaultive behaviors	☐	☐	
Self-Mutilating Behaviors	☐	☐	
Physical abuse	☐	☐	
Verbal/Emotional Abuse	☐	☐	
Sexual Abuse	☐	☐	

PARENTAL SUBSTANCE USE HISTORY:
(indicate all that applies)

Have you ever used alcohol or non prescriptions drugs? ☐*yes* ☐*no* If yes, please describe below:

Type	How Much	How often	Age started	Date last used

Have you or anyone in the immediate family been to a substance abuse program? If yes, whom and when: _____

Does anyone in the family use tobacco products? Yes☐ No☐

If yes, please list family members and packs per day: _____

Family members affected by alcohol or drug abuse/dependence: Check all that apply and describe below:
Mother ☐ ***Father*** ☐ ***Sister*** ☐ ***Brother*** ☐ ***Grandfather*** ☐ ***Grandmother*** ☐
Other ☐
Describe: _____

To your knowledge, has this child/adolescent ever used:
Alcohol? *Yes*☐ *No*☐
Tobacco? *Yes*☐ *No*☐
Marijuana? *Yes*☐ *No*☐
Other substance? *Yes*☐ *No*☐

*If yes, please explain:*_____

LEGAL

Have there been any arrests in the family?
If you answered yes to the above question please explain below:

MEDICAL

Childhood/Disorders/Diseases (describe any complications):
Hospitalizations for illness:

Head injuries:
Allergies:
Current medical condition:
Is there family history of any significant medical concerns? Conditions: Family Member: 1. 2. 3.

PREVIOUS/PRESENT TREATMENT
(Obtain a release of information if applicable)

Has this child/ adolescent had any psychiatric hospitalizations?		
When: Counselor/Psychiatrist Name:	Where:	Reason:
Has your child received previous counseling?		
When: Counselor/Psychiatrist Name:	Where:	Reason:
Has your child ever been in a foster home or other shelter?		
When: Counselor/Psychiatrist Name:	Where:	Reason:
Has this child/ adolescent in-school counseling?		
When: Counselor/Psychiatrist Name:	Where:	Reason:

Was the treatment your child received successful? ☐ Yes ☐ No

Explain:

How did you/your child feel about the previous counseling experience?

Is there any additional information you would like for your therapist to know? (i.e. Additional traumas, deaths, illnesses, or anything else that may not seem relevant) _____

_____

_____

Name of Parent/Guardian Interviewed: _____

Relationship to Child: _____

Parent/Guardian Signature: _____ **Date:** _____

Therapist's Signature: _____ **Date:**_____