SANTA ROSA
COUNSELING CENTER
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# CHILD/ADOLESCENT 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 ❑ Parent/Guardian/Representative ______________________________
Name Relationship

______________________________________________
Last Name First Middle

______________________________________________
Residence Address City State Zip Code

______________________________________________
Date of Birth Age Social Security Number

______________________________________________
Telephone (Home) (Cell) (Parent/Guardian)

Gender:

❑ Male ❑ Female

## PERSONAL HISTORY

Why are you seeking treatment at this time?

______________________________________________

______________________________________________

______________________________________________

What has been done so far to address these concerns?

______________________________________________

______________________________________________

Are you here for reasons related to abuse or violence? ❑ Yes ❑ No

If yes, do you wish to provide more information at this point?

______________________________________________

______________________________________________

**STAFF NOTES**

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In what areas do you need help? (Check all that apply)

- ❑ Anger management
- ❑ Depression
- ❑ Housing
- ❑ Trauma/Abuse
- ❑ Anxiety
- ❑ School
- ❑ Substance use/abuse
- ❑ Grief/Death/Loss
- ❑ Family
- ❑ Legal/Juvenile Justice
- ❑ Significant relationship
- ❑ Behavior
- ❑ Employment/Work
- ❑ Other ______________________________

STAFF NOTES

## MENTAL HEALTH

Have you had any of the following within the past 90 days? (Check all that apply)

- ❑ Suicidal thoughts
- ❑ Depression
- ❑ Anxiety
- ❑ Suicide attempts
- ❑ Hyperactivity
- ❑ Panic/phobia
- ❑ Self injury
- ❑ Panic attack
- ❑ Fire setting
- ❑ Obsessive/intrusive thoughts
- ❑ Death in family
- ❑ Poor sleep patterns
- ❑ Thoughts of harming others
- ❑ Mood swings
- ❑ Weight gain/loss
- ❑ Violence
- ❑ Cruelty to animals
- ❑ Racing Thoughts
- ❑ Hallucinations (voices/visions)
- ❑ Paranoia/Delusions
- ❑ Agitation/Irritability

Have you ever been in counseling before? ❑ Yes ❑ No

If yes: ______________________________________________

Date Location Counselor

Are you currently taking behavioral health medications? ❑ Yes ❑ No

If yes, please list:

| Medication | Dose | Doctor | Reason | Taking as prescribed? |
|---|---|---|---|---|
| | | | | |
| | | | | |

Have you ever taken behavioral health medications in the past? ❑ Yes ❑ No

If yes, please list:

| Medication | Dose | Doctor | Reason | Taken as prescribed? |
|---|---|---|---|---|
| | | | | |
| | | | | |

Have you ever been hospitalized for behavioral health reasons? ❑ Yes ❑ No

If yes: ______________________________________________

Date Location Doctor

What were your previous mental health diagnoses?

______________________________________________

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STAFF NOTES

## MEDICAL

Who is your primary care physician?

__________________________________________________
Doctor Address/Location

Please indicate any medical problems you have had or currently have? (Check all that apply)

| | | |
|---|---|---|
| ❑ Asthma | ❑ Head injury | ❑ Sinus/Allergies |
| ❑ Back/neck injury | ❑ Hearing impairment | ❑ Speech impairment |
| ❑ Cancer | ❑ Heart problems | ❑ Visual impairment |
| ❑ Developmental disability | ❑ Physical impairment | ❑ Wetting/soiling (day/night) |
| ❑ Diabetes (sugar) | ❑ Seizures | ❑ Other ____________ |
| ❑ Gastrointestinal | ❑ STD ____________ | |

## VOCATIONAL/EDUCATIONAL

________________________________ ❑ Regular ❑ ESE ❑ Gifted
School Grade

Check which behaviors are problematic: (Check all that apply)

| | | |
|---|---|---|
| ❑ Tardy/Skipping class | ❑ Excessive absences | ❑ Poor performance |
| ❑ Disruptive/Defiant | ❑ Dropped out | ❑ Suspended |
| ❑ Social problems | ❑ Repeated grade | ❑ Expelled |

## LEGAL

| | | |
|---|---|---|
| Have you been arrested in the past two years? | ❑ Yes | ❑ No |
| Are you involved with a DFC/FFN case or investigation? | ❑ Yes | ❑ No |
| Are you court ordered for services? | ❑ Yes | ❑ No |
| Are you currently assigned to a probation officer or caseworker? | ❑ Yes | ❑ No |

If yes: ____________________________________________
Name Phone

Will you require a progress note for legal authorities? ❑ Yes ❑ No

## SUBSTANCE USE

Explain any family history of substance abuse:

__________________________________________________

__________________________________________________

Have you used or are you currently using any drugs or alcohol? ❑ Yes ❑ No

*An additional section may be completed during your session if substance use or abuse is indicated.*

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## FAMILY HISTORY

Who is/are your primary caregiver(s)/guardian(s)? ______________________________

My relationship with my caregiver(s)/guardian(s) is:

❑ Good ❑ Fair ❑ Poor ❑ Not applicable

How many siblings do you have? _______ brothers _______ sisters

My relationship with my siblings is:

❑ Good ❑ Fair ❑ Poor ❑ Not applicable

How many close friends do you have? ____________________

## RECOVERY ENVIRONMENT

What are your interests and what do you do for fun?

______________________________________________________________________

______________________________________________________________________

Do you attend church or participate in other religious activities? ❑ Yes ❑ No

Describe your home environment:

______________________________________________________________________

Who or what gives you hope?

______________________________________________________________________

Who is your primary emotional support?

______________________________________________________________________

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

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Patient Name Patient Signature

______________________________________________________________________

Parent/Guardian Name Parent/Guardian Signature

______________________________________________________________________

Clinician Credentials Clinician Signature