Child and Adolescent Behavioral Assessment

Demographic Information

Client Name _____ Medical Record Number_____

Date of Birth _____ Assessment Date: _____ Age: _____ Male/Female _____Race _____

School _____ Grade _____

Parent(s)/Guardian(s)/Legally Responsible Person(s)

_____

_____

Address City Zip County

Home/Cell/Work Numbers _____ [redacted] _____

Name/Contact number of referral source_____

Other professionals involved (e.g. DJJ,DSS) _____

Primary Care Physician or Practice _____ Tel. #_____

Currently receiving mental health services? YES / NO

If yes, with whom:_____ Type of Service_____

Name Contact Number

Presenting Symptoms/Problems:

_____

_____

_____

_____

_____

Developmental History (Check all that apply):

☐ No information/unknown

☐ Developmental milestones met within normal limits (Crawling, walking, talking)

☐ Developmental delays (explain) _____

☐ Prenatal Complications

☐ Prenatal drug use/abuse/exposure

Abuse/Neglect/Trauma History (Check all that apply):

☐ Denies history ☐ Physical abuse ☐ Emotional abuse ☐ Sexual Abuse ☐ Neglect

☐ Perpetrator was identified (relationship to client) _____

☐ Sexual assault/rape ☐ Domestic Violence ☐ Witness to trauma:_____

☐ Age at time of abuse/trauma: _____

Psychiatric History (Check all that apply):

☐ Denies history ☐ Inpatient/hospitalization ☐ Outpatient treatment ☐ Residential treatment

(Specify) _____

Psychiatric medication was / was not helpful (list) _____

Current medications: _____

Current Strengths and Needs (Check all that apply within the following 6 domains):

Interpersonal/Social

☐ Positive Relationship with Caregiver/Parent ☐ Positive Relationship with siblings

☐ Other significant person(s) _____ ☐ Positive relationship with peers

Comments: _____

_____

Financial (Rate Caregiver if client is a minor)

☐ Medicaid/Medicare/Private Insurance ☐ Stable Income ☐ Stable Employment

☐ Needs food assistance ☐ Needs financial assistance ☐ Needs financial/budgeting skills

Comments: _____

_____

Environmental/Client lives with:

☐ Stable housing ☐ Safe housing ☐ Safe neighborhood/community ☐ Biological Parent(s)

☐ Foster Parent(s) ☐ Family Member ☐ Other relatives ☐ staffed home/facility (level) _____

Comments: _____

_____

Educational/Vocational

☐ Currently enrolled in school (Type of classroom) _____

☐ Individualized/Behavioral Education Plan/Special Education _____

☐ Plan needed/Educational assistance needed _____

Physical Health

☐ Medical needs ☐ Dental needs ☐ Vision needs ☐ Physical disability ☐ Cognitive Impairment

☐ Currently pregnant ☐ Current medications _____

Medical Provider _____

Physician's name and contact information _____

Comments: _____

Emotional Health/Current Symptoms

- **Suicide/Self harm**

☐ Suicidal ideation (ex: "I can't take it anymore, I wish I could just disappear") ☐ Has a plan for suicide

☐ Suicide attempt in past ☐ Suicide attempt in recent history (date/description): _____

☐ Self-Injurious Behaviors (ex: picking and pinching or carving on skin, chronic runaway, poor judgment)

☐ Other harmful behavior (ex: homicidal ideation) _____

Emotional Health/Current Symptoms, (continued)

- **Psychotic/Dissociative Symptoms (Check and Specify Type)**

☐ Hallucinations ☐ Delusions ☐ Paranoia ☐ Unusual Speech ☐ Unusual Behavior

_____

☐ Other (describe) _____

- **Attention/Behavioral Symptoms**

☐ Hyperactive ☐ Impulsive ☐ Physical aggression ☐ verbal aggression

☐ Destruction of property ☐ Theft without confronting a victim ☐ Theft while confronting a victim

☐ Serious violation of rules/laws ☐ Oppositional/Defiant ☐ Disruptive (home or school)

☐ Other (describe)

_____

_____

- **Cognitive Impairment**

☐ Learning Disability ☐ Traumatic Brain Injury ☐ Developmental Disability

☐ Mental Retardation (Circle severity) Mild Moderate Severe/Profound

☐ Communication Disorder (Speech delay, Impediment, Impairment)

(If available) Full Scale Intelligence Quotient (FSIQ) _____ Date identified: _____

☐ Other (describe) _____

- **Stress, Anxiety, Trauma**

☐ Panic attacks ☐ Anxiety ☐ Phobia (specify) _____

☐ Compulsive behavior (specify) _____ ☐ Obsessive thoughts (Specify) _____

☐ Flashbacks (Intrusive recollections of past traumatic events) ☐ Avoidance ☐ Nightmares

☐ Psychomotor agitation (e.g. pacing, wild gesticulating) ☐ Psychomotor retardation (e.g. "sluggish")

☐ Other (describe) _____

- **Mood and Adjustment**

☐ Depression (sadness) ☐ Euphoria (intense elation) ☐ Grandiosity (excessive sense of self-importance)

☐ Unstable/Inconsistent moods ☐ Other _____

☐ Insomnia ☐ Hypersomnia ☐ Sleep Disturbance ☐ Weight Gain ☐ Weight Loss (#lbs: _____)

☐ Excessive reaction to identifiable stressor: (ex: death of spouse, immigration, victim of assault)

_____

_____

_____

- **Substance Abuse/Use**

☐ Current substance use ☐ History of substance use ☐ In recovery ☐ Substance abuse treatment needed

Describe choice of substance, frequency and length of use

_____

_____

Current Mental Status of Youth:

Grooming: ___Well-groomed ___Disheveled ___Unkempt ___Other_____

Dress: ___ Normal ___Underdressed ___Bizarre ___Other_____

Movements: ___ Within normal limits ___Decreased, slow ___Restless, fidgety ___Atypical, peculiar ___Other_____

Speech: ___Fluent ___Coherent ___Pressured ___Expansive ___Decreased ___Other_____

Attention/Concentration: ___Focused ___Easily distracted ___Inattentive ___Other_____

Estimated Intellectual Functioning: ___Above Average ___Average ___Below Average

Insight: ___Good ___Fair ___Poor ___Denies/minimizes ___Blames others ___Other_____

Diagnoses (Code and List):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: (Specify) _____

Areas needing improvement for client (Check all that apply):

(example: social skills, communication skills, behavior management skills)

_____

_____

_____

_____

Recommendations (Check all that apply):

- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Psychological testing (Reason:_____)
- ☐ Psychiatric/Medication Evaluation and possible subsequent Monitoring
- ☐ Clinical Assessment/Reassessment of diagnosis –
- ☐ Specialized Treatment (Ex: Substance Abuse Counselor, Family Therapy) _____
- ☐ Intensive in-home Services
- ☐ Other (please specify) _____

Professional Completing Report:

_____ Credentials _____ Date _____

Signature

_____

Printed Name