CHILD/YOUTH PRE-ASSESSMENT

UNDER 17 ONLY

Date: ________________

Phone: 601-939-6634

Fax: 601-420-9252

www.crossroadscounselingms.com

Child's Name: ____ Age: _______________ Gender: M or F

Your Name: ____ Relationship To Child: ______________________

Are you the Legal Guardian: YES NO

Please briefly describe why you are seeking help for your child:

____

____

If you had to describe major symptoms for which you are seeking therapy for your child, they would be:

- ❏ Depression
- ❏ Anxiety
- ❏ General Sadness
- ❏ Mood Swings
- ❏ Obsessive Worries
- ❏ Panic Anxiety
- ❏ Times of Confusion
- ❏ Anger
- ❏ Change in Appetite
- ❏ Loss of Memory
- ❏ Drug Abuse
- ❏ Inattention/Hyperactivity
- ❏ Behavioral Problems
- ❏ Grief
- ❏ Self Esteem Issues
- ❏ Other: ______________

Please check the major stressor(s) that preceded or accompanied your child's symptoms:

- ❏ Parent's Marital Issues
- ❏ Parent/Child Issues
- ❏ School Issues
- ❏ Health Issues
- ❏ Trauma
- ❏ Bullying
- ❏ Adjustment to Divorce
- ❏ Significant Change in Family Situation
- ❏ Loss of Significant Person in Child's Life
- ❏ New Addition to the Family (Birth, Adoption, or other)
- ❏ Adoption Issues
- ❏ Relationship or Family Issues
- ❏ Blended Family Issues
- ❏ Other: __________________

The symptoms began ______ (weeks / months) ago and have been (increasing) (decreasing) (no change)

My three biggest concerns for my child at the present time are:

1. ____
2. ____
3. ____

Please state your goals for therapy:

1. ____
2. ____
3. ____

CHILD / YOUTH PRE-ASSESSMENT

Please check all of the following that your child has experienced and how often:

Some Weekly Daily

- ◯ ◯ ◯ Increased Crying
- ◯ ◯ ◯ Poor Concentration
- ◯ ◯ ◯ Change in Sleep Pattern
- ◯ ◯ ◯ Appetite Changes
- ◯ ◯ ◯ Weight Changes
- ◯ ◯ ◯ Lack of Interest in usual activities
- ◯ ◯ ◯ Decreased Self-Esteem
- ◯ ◯ ◯ Hopelessness/Helpless Feeling
- ◯ ◯ ◯ Being Withdrawn
- ◯ ◯ ◯ Nightmares
- ◯ ◯ ◯ Rapid Heartbeat
- ◯ ◯ ◯ Increased Sweating
- ◯ ◯ ◯ Shortness of Breath
- ◯ ◯ ◯ General Anxiety
- ◯ ◯ ◯ Chest Discomfort
- ◯ ◯ ◯ Feeling Dizzy
- ◯ ◯ ◯ Chills or Hot Flashes (Circle which one)
- ◯ ◯ ◯ Outburst of Anger
- ◯ ◯ ◯ Restlessness, keyed up, irritability, muscle tension, decreased sleep (Circle which one)
- ◯ ◯ ◯ Stomach Issues
- ◯ ◯ ◯ Startled Response
- ◯ ◯ ◯ Feeling 'High" with racing thoughts, increases speech, decreased sleep, and increased activity or energy level
- ◯ ◯ ◯ Preoccupation w/ Particular things or people. List: ____
- ◯ ◯ ◯ Hyper Vigilance Excessive attention and focus on things or people
- ◯ ◯ ◯ Inattention
- ◯ ◯ ◯ Hyperactivity
- ◯ ◯ ◯ Impulsiveness
- ◯ ◯ ◯ Excessive Fears
- ◯ ◯ ◯ Obsessions/Compulsions - constant checking, washing, or counting type behaviors; unrelenting worries
- ◯ ◯ ◯ Hallucinations (hearing voices/music that no one else hears)
- ◯ ◯ ◯ Avoidance of anything associated with a trauma experienced
- ◯ ◯ ◯ Post Traumatic Stress experiences. List: ____
- ◯ ◯ ◯ Fear or Anxiety of any places or inescapable situation
- ◯ ◯ ◯ Social Phobia (persistent fear of social or performance situation where embarrassment may occur)
- ◯ ◯ ◯ Specific Phobia (persistent fear of certain objects or situations) List: _________________________________
- ◯ ◯ ◯ Isolating Self from all contact with others
- ◯ ◯ ◯ Amnesia
- ◯ ◯ ◯ Running Away
- ◯ ◯ ◯ Truancy
- ◯ ◯ ◯ Memory impairment with trouble organizing thoughts
- ◯ ◯ ◯ Undue health worries with no adequate explanation
- ◯ ◯ ◯ Agitated-irritable (easily annoyed and provoked to anger)
- ◯ ◯ ◯ Suspiciousness
- ◯ ◯ ◯ Delusions/Paranoia. Explain: ____

CHILD / YOUTH PRE-ASSESSMENT

Please check all of the following that your child has ever experienced:

◯Behavioral Problems. Explain: ____
◯Self Mutilation (cutting, etc.) Last occurrence: _______________
◯Eating Issues (under or over eating, binging, or purging) Specify: __________________
◯Birth Trauma. Explain: ____
◯Serious Health Issues. Explain: ____
◯Surgeries or intrusive medical interventions. Explain: _____________________________________
◯Accidents (what kind, when, injuries sustained) ____
◯Suicidal Thoughts. If yes, last known occurrence: _____________________ Describe the situtaion and nature of the thoughts:____
◯Suicide Attempts. If yes, when and how: ____

Medical History

Please list any **psychiatric** medications your child is currently taking:

Medication	Date Began	Side Effects
1.		
2.		
3.		
4.		

Are you aware of the diagnosis given to treat your child with these medications? YES NO
If yes, Please describe diagnosis: ______________________________________ Diagnosed by Whom? _______________

Has your child been to counseling before? YES NO When? _________ Where? ___________________________ Reason?
____

Has your child ever been hospitalized for a psychiatric disorder? YES NO
Please Explain:
____
____
____

Please describe any current medical conditions your child may have: (diabetes, asthma, etc.)
____
____

Please list any supplements or vitamins your child takes:
____
____

CHILD / YOUTH PRE-ASSESSMENT

Please list any ***Non*-psychiatric** medications your child is currently taking:

Medication	Date Began	Side Effects

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

School History

What grade is your child in? ___________ School currently attending? ______________________________

What kind of student is your child? ______________________________

Does your child get along with their peers at school? ______________________________

Does your child have a condition that affects their performance, such as dyslexia, ADD, or ADHD? ______________________________

Current Family

Describe Child's relationship with Father:

____
____
____

Describe Child's relationship with Mother:

____
____
____

Describe Child's relationship with Step-Father:

____
____
____

Describe Child's relationship with Step-Mother:

____
____
____

Describe Child's relationship with siblings: (how many, where child is in birth order)

____
____
____

CHILD / YOUTH PRE-ASSESSMENT

In general, you would describe your family climate as:

- ❏ Pleasant
- ❏ Great
- ❏ Normal amount of fussing but generally good
- ❏ Abusive
- ❏ Chaotic
- ❏ Disconnected
- ❏ Dysfunctional
- ❏ Other: ___________________

Description of Current Family where Child Resides

Who lives in the home with the child?

____

Are there any siblings of significant others who do NOT live in the home with this child? YES NO
Who are they and where do they live? ____

Are there other relatives who are significant in this child's life? (Ex. grandparents and the child's name for them.)

____

Does the child live with anyone else, i.e. split custody? Describe this arrangement.

____
____
____

(Please bring in the custody portion of your divorce papers or guardianship papers if you are guardian of this child.)

Please use the space below to add any other information that you feel is important for the therapist to know regarding the Current Family or Home Situation:

CHILD / YOUTH PRE-ASSESSMENT

Parent/Guardian Information

(For parent with child today)

Name: ______________________________ Married? YES NO How many years? ___________

Divorced? YES NO How many years? ___________

I presently live with:
- ❏ Spouse
- ❏ Alone
- ❏ Parents
- ❏ Other: ________________________

My sexual orientation is:
- ❏ Heterosexual
- ❏ Homosexual
- ❏ Other: __________

My current support system (including family and friends) is:
- ❏ Good
- ❏ Fair
- ❏ Poor

Please describe any current stress in your family/marriage?

____

____

____

(Other Parent Information)

Name: ______________________________ Married? YES NO How many years? ___________

Divorced? YES NO How many years? ___________

I presently live with:
- ❏ Spouse
- ❏ Alone
- ❏ Parents
- ❏ Other: ________________________

My sexual orientation is:
- ❏ Heterosexual
- ❏ Homosexual
- ❏ Other: __________

My current support system (including family and friends) is:
- ❏ Good
- ❏ Fair
- ❏ Poor

Please describe any current stress in your family/marriage?

____

____

____

Drug/Alcohol History

Does either parent have a history of drug or alcohol addiction? YES NO

Which parent(s)? ____

Addiction? ____

Describe treatment and absences which have affected child:

____

Religious Beliefs

Do you consider yourself religious/spiritual?

- ❏ Yes
- ❏ No
- ❏ Somewhat
- ❏ In the Past

What has been your child's main spiritual influence?

- ❏ Church
- ❏ Family
- ❏ Other: __________

Do you attend church?

- ❏ Never
- ❏ Rarely
- ❏ Occasionally
- ❏ Once a month
- ❏ Nearly every week or more

Church to which you belong or attend? ____________________________

School/Career

What level of school did you complete?

- ❏ Middle School
- ❏ High School
- ❏ GED or Equivalent
- ❏ College
- ❏ Graduate or Professional Degree
- ❏ Other: ________________
- ❏ Currently in School (Level: ________________)

What level of school did the child's other parent complete?

- ❏ Middle School
- ❏ High School
- ❏ GED or Equivalent
- ❏ College
- ❏ Graduate or Professional Degree
- ❏ Other: ________________
- ❏ Currently in School (Level: ________________)

Please use the space below to add any information that was not covered or mentioned that you feel is important for the therapist to know in regards to your child:

____

____

____

____

____