

**BRIDGEPOINTE PSYCHOLOGICAL &
COUNSELING SERVICES**

Name: _____
SS#: _____
Case ID# _____

CHILD/ADOLESCENT ASSESSMENT
Page 1

Date: _____

DO YOU OR YOUR CHILD/ADOLESCENT HAVE ANY PHYSICAL IMPAIRMENTS OR LIMITATIONS WHICH MAY REQUIRE SPECIAL ACCOMMODATIONS, SPECIAL ARRANGEMENTS, OR MAY AFFECT YOUR ABILITY TO PARTICIPATE IN YOUR CHILD'S/ADOLESCENT'S ASSESSMENT OR TREATMENT OR THAT MAY AFFECT YOUR CHILD'S/ADOLESCENT'S TREATMENT (i.e., reading difficulties, hearing loss, vision loss, speech impairment)?

Yes No If yes, please explain: _____

CURRENT SITUATION:

What concern brings you here: (How long has this been a problem?)
(What have you done, or are you doing, to resolve this problem?)

What do you hope to accomplish in this session/in therapy?

DEVELOPMENTAL HISTORY

PRENATAL/BIRTH HISTORY:

Health of mother: Good Fair Poor Do not know

Did the mother use any of the following during pregnancy?

Alcohol Marijuana/Cocaine/Crack
 Cigarettes Prescription Drugs (list): _____
 Coffee/Caffeine Drinks None of the above Do not know

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DEVELOPMENTAL HISTORY (cont.)

Any medical complications during pregnancy? Yes No

Comments: _____

Length of Pregnancy in months or weeks if known: _____ Birth Weight _____

Were there any complications during or following birth? (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Baby given oxygen | <input type="checkbox"/> Incubator | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Baby on heart monitor | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Very active |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Problems breathing | <input type="checkbox"/> Very quiet |
| <input type="checkbox"/> Blood transfusions (baby) | <input type="checkbox"/> Problems eating/digestion | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Delivery aided by instrument | <input type="checkbox"/> Problems sucking | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Delivery by cesarean section | | |

EARLY DEVELOPMENT:

Your child's/adolescent's approximate age when he/she began:

walking at _____ months; talking (single words) at _____ years; talking (short sentences-2+ words) at _____ years; toilet training: daytime at _____ years and nighttime at _____ years.

Overall, you feel your child/adolescent developed at the following rate: Slow Normal Rapid

Comments: _____

During the first three years of life, your child frequently exhibited: (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Accident prone behavior | <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Restless behavior |
| <input type="checkbox"/> Avoidance of cuddling | <input type="checkbox"/> Head banging | <input type="checkbox"/> Self-hurting behavior |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Destructive behavior | <input type="checkbox"/> Overactive behavior | <input type="checkbox"/> Unresponsive to discipline |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Problems with sleeping/waking patterns | <input type="checkbox"/> Withdrawn behavior |
| <input type="checkbox"/> Extreme mood changes | | <input type="checkbox"/> None of the above |

Comments: _____

SEXUALITY:

Is your child/adolescent: Prepubescent Pubescent For females, menstruation began at _____(age)

To the best of your knowledge, your child/adolescent is:

- | | | | |
|----------------------|------------------------------|-----------------------------|----------------------------------|
| Sexually active | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Uses contraceptives | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| History of pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| History of abortion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Fathered a child | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

Do you have any concerns regarding your child's/adolescent's sexual development or sexual orientation?

Yes No

Comments: _____

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DEVELOPMENTAL HISTORY (cont.)

SIGNIFICANT EVENTS:

- | | |
|--|--|
| <input type="checkbox"/> Change of school | <input type="checkbox"/> Move to a new place |
| <input type="checkbox"/> Death in family | <input type="checkbox"/> Serious illness or injury to family member/friend |
| <input type="checkbox"/> Divorce or separation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Frightening experience for child/adolescent | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Loss of someone close to child/adolescent | |

Comments: _____

HEALTH/MEDICAL HISTORY:

Primary Care Physician/Pediatrician _____

Current: Height _____ Weight _____

Does your child/adolescent have any drug/food allergies? Yes No If yes, please specify:

Are childhood immunizations up to date? Yes No Do not know

Does your child/adolescent have an eating or sleeping problem? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Dieting | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Overeats | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Trouble staying asleep |
| <input type="checkbox"/> Picky eater | <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Very restless at night |
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Does not want to sleep alone | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Nightmares | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Refuses to eat | <input type="checkbox"/> Sleeps too much | |

How would you describe the nutritional value & balance of your child's/adolescent's diet: Good Fair Poor

Has your child/adolescent been diagnosed and/or currently being treated for any of the following?
(Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fever above 105° | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Musculo-Skeletal Condition |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Loss of consciousness | |

Comments: _____

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ACTIVITIES OF DAILY LIVING:

Check areas of difficulty your child/adolescent displays when performing daily activities:

- | | |
|--|--|
| <input type="checkbox"/> Adapting to changes | <input type="checkbox"/> Goal setting |
| <input type="checkbox"/> Attending to tasks | <input type="checkbox"/> Learning |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Performing self-care (hygiene, grooming, bathing, etc.) |
| <input type="checkbox"/> Following a routine | <input type="checkbox"/> Problem Solving |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None of the above |

Comments: _____

CULTURAL/ETHNIC/SPIRITUAL:

Cultural/ethnic/racial issues that need consideration: _____

Religious/spiritual issues that need consideration: _____

EDUCATION:

School presently attending: _____ Grade _____

School related issues: (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Academic problems | <input type="checkbox"/> Held back a grade | <input type="checkbox"/> Required special help |
| <input type="checkbox"/> Advanced a grade | <input type="checkbox"/> Homework | <input type="checkbox"/> Suspension/expulsion |
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Met with school counselor | <input type="checkbox"/> Tested by school psychologist (ADD, ADHD, other) |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Detention | <input type="checkbox"/> Relationship with teacher(s) | <input type="checkbox"/> None of the above |

Comments: _____

FAMILY HISTORY:

List all the people who are currently living in the household:

Name	Age	Relationship to child/adolescent
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List sibling(s) not living in the household:

Name	Age	Relationship to child/adolescent
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_____	_____	_____
_____	_____	_____
_____	_____	_____

