Children's Program – Behavioral Health Services

Psychosocial and Family Assessment

IDENTIFYING INFORMATION

Date_____ (***To be filled out by legal guardian or with their assistance***)

_____

Child's first name Middle name Last name

Race _____ Hospital where born _____ Location _____

Child's Address: _____City_____ State_____

Zip Code _____ Child's Home Phone number: _____ Child's SS#:_____

Child's birth date_____ Child's age_____

How long has the patient lived in the current location? _____

Where else has the patient lived in the past five years? _____

_____

Who is the legal guardian of the child: _____

Guardian's Address (if not parent & if different than child's) _____

City _____ State_____ Zip Code_____ Guardian's Home Phone #_____

Guardian's Work Phone #_____ Guardian's Cell Phone #_____

Emergency Contact _____ _____

Name Relationship

Home #_____ Work #_____ Cell #_____

FAMILY HISTORY

How long were the biological parents together? _____

Are the parents currently: MARRIED LIVING TOGETHER SEPARATED DIVORCED

If separated/divorced, when did the separation/divorce take place? _____

Have the parents had additional marriages? **YES** **NO** If "YES", please identify date(s) of marriage(s) and divorce(s):

_____

Does the child have contact with both biological parents? **YES** **NO, why?** _____

_____

Is it okay to contact non-custodial parent? Yes No If no, explain _____

Biological parents married when child was born? **YES** **NO**

If not together, date of parental separation (divorce, breakup, etc.) _____

Name of Biological Father: _____DOB_____ SS#_____

1. Parental rights terminated? **NO YES WHEN** _____
2. Address_____ City_____ State_____ Zip Code _____
3. Phone: home#_____ cell# _____ wk#_____
4. Employer_____ Occupation_____
5. Level of Education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other:_____
6. Mental illness, father or family? **NO YES:**_____
   _____
7. Substance abuse, father or family? **NO YES:** _____
8. Any learning disabilities in family? **NO YES:** _____
9. Military service history: **NO YES:** _____
10. Any previous marriages? **NO YES:** _____# of kids from previous marriage: _____
11. How did parent get along with own parents? _____
12. How does child get along with him? _____

Name of Biological Mother: _____DOB_____SS#_____

1. Parental rights terminated? **NO YES WHEN** _____
2. Address_____ City_____ State_____ Zip Code _____
3. Phone: home#_____ cell# _____ wk#_____
4. Employer_____ Occupation_____
5. Level of Education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other:_____
6. Mental illness, mother or family? **NO YES:**_____
   _____
7. Substance abuse, mother or family? **NO YES:** _____
8. Any learning disabilities in family? **NO YES:** _____
9. Military service history: **NO YES:** _____
10. Any previous marriages? **NO YES:** _____ # of kids from previous marriage: _____
11. How did parent get along with own parents? _____
12. How does child get along with her? _____

Other Adult involved with patient: _____DOB_____SS#_____

Relationship to child: **Adoptive Parent Step Parent Legal Guardian Foster Parent Or: _____**

1. Address_____ City_____ State_____ Zip Code _____
2. Phone: home#_____ cell# _____ wk#_____
3. Employer_____ Occupation_____
4. Level of Education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other:_____
5. Mental illness, parent or family? **NO YES:**_____
6. Substance abuse, parent or family? **NO YES:** _____
7. How does child get along with _____

Other adult involved with patient: _____DOB_____SS#_____

Relationship to child: **Adoptive Parent Step Parent Legal Guardian Foster Parent Or:_____**

1. Address_____ City_____ State_____ Zip Code _____
2. Phone: home#_____ cell# _____ wk#_____
3. Employer_____Occupation_____
4. Level of Education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other:_____
5. Mental illness, parent or family? **NO YES:** _____
6. Substance abuse, parent or family? **NO YES:** _____
7. How does child get along with _____

Who is responsible for child's discipline _____

Place a check by any of the following methods used

☐ Time out ☐ Restrictions ☐ Loss of privileges ☐ Spanking ☐ Limited choices ☐ Praise ☐ Rewards

☐ Other _____

Is there a Guardian Ad Litem involved? Name_____ phone#_____

How long has the involvement been? _____

Siblings: (**H**-Half, **F**-Full, **S**-Step, **A**-Adoptive)

Name	Gender	Age	Relationship	Where do they live
1) _____	**M F**	____	**H F S A**	_____
2) _____	**M F**	____	**H F S A**	_____
3) _____	**M F**	____	**H F S A**	_____
4) _____	**M F**	____	**H F S A**	_____

Relationship with siblings: _____

_____

Who is currently living in the home? _____

_____

Is there any information that cannot be disclosed to the patient at this time? **NO YES (explain) _____**

_____

_____

CURRENT LEVEL OF FUNCTIONING

Behavioral Profile (Put a star beside any behavior that has occurred in past month) If it is not a problem write *NO* for that question.

Describe any suicidal or self-harming behavior: _____

_____

_____

Describe any homicidal or assaultive behavior(onset, triggers) : _____

_____

_____

Describe any depression (onset, duration, what makes it worse): _____

_____

Describe any psychotic behavior (onset, duration, triggers): _____

_____

Describe the child's usual mood: _____

_____

Describe any mood swings: _____

_____

Describe any significant losses: _____

Describe any pyromania (fire setting): _____

_____

Describe any stealing: _____

_____

Describe any cruelty to animals: _____

_____

Describe any verbal abuse/swearing: _____

_____

Describe any history of temper tantrums (If previous, when tantrums stopped?):_____

_____

Describe any destruction of property/vandalism: _____

_____

Describe any day or night time wetting, soiling clothes, or urinating in inappropriate places: _____

_____

Describe extent of any alcohol use or drug use or smoking: _____

_____

Describe any lying: _____

_____

Describe any running away: _____

_____

Describe any poor hygiene: _____

_____

Describe any impulsive behavior (doing without thinking): _____

_____

Describe any problems with memory or concentration (onset): _____

_____

Describe any risky behavior: _____

_____

Describe any problems playing with others (is child invited to others' houses for day, overnight?): _____

_____

Describe any problems with peer group (what is typical relationship like with peers?): _____

_____

Describe any inappropriate sexual behavior (public masturbation, fondling, exposing self, etc.):_____

_____

How has the family reacted to the patient's problems? _____

_____

PAST TREATMENT HISTORY

Where has the patient received therapeutic services in the past? (Most recent first, **I**-Inpatient, **O**-Outpatient)

	Name of Agency/Therapist	Dates	Level	Primary Referring Problem(s)
1)	_____	_____	**I O**	_____
2)	_____	_____	**I O**	_____
3)	_____	_____	**I O**	_____
4)	_____	_____	**I O**	_____
5)	_____	_____	**I O**	_____

Other services received: (and reasons previous services were stopped)

Case Management: _____

In Home Family Based Services/Dates: _____

Parenting Classes/Dates: _____

Neurological Evaluations/Dates: _____

Any Psychological Testing done? **NO YES** _____

When: _____ Where:_____ By whom:_____

Why: _____ I.Q._____

Who referred you to the Children's Program? _____

CHILD'S MEDICAL HISTORY

List any drug allergies_____

Child's current height _____ Child's current weight _____

Child's family doctor _____ Office name_____ Phone #_____

Has your child had problems with any of the following:

Three or more ear infections? **NO YES** _____

Difficulty urinating or urinary infections? **NO YES** _____

Constipation? **NO YES** _____ Diarrhea? **NO YES** _____

Seizures/convulsions **NO YES** _____

Describe any sleep problems: (onset, what makes it worse, frequency of problem) _____

_____

Describe any appetite problems (onset, what makes it worse, frequency of problem): _____

Describe your child's eating habits/preferences_____

Has your child had a change in appetite? **NO YES**

_____

Does your child follow a special diet? **NO YES**

_____

Have there been any weight changes in last six months? **NO YES**

_____

Does your child have any food allergies? **NO YES**

_____

Does your child wear braces or a retainer? **NO YES** _____

Who is your child's orthodontist? _____

Has your child had recent cavities or tooth pain? **NO YES**

_____

When was your child's last dental visit? _____ Name of dentist _____

Hearing problems? **NO YES** _____

Date/Place of last hearing test_____

Vision problems? NO **YES**

_____

Date/Place of last vision exam _____

Allergies **NO YES** _____

Check if the child has had any of the following illnesses and when.

If none of these check here ☐

☐ Roseola _____ ☐ Red Measles_____ ☐ German measles (Rubella) _____

☐ Mumps _____ ☐ Chicken Pox _____ ☐ Asthma _____ ☐ Jaundice _____

☐ Pneumonia _____ ☐ Broken Bones _____ ☐Whooping cough _____

☐ Tonsils removed _____ ☐ Adenoids removed _____

Describe any significant illnesses_____

_____

_____

List any hospitalizations (reasons, dates, age of child) _____

_____

_____

List any outpatient surgeries (reasons, dates, age of child) _____

_____

_____

Has your child had a head injury in the past? **NO YES** When_____

Loss of consciousness? **NO YES** Describe _____

Has your child had any of the following tests? If so, please state why, when and where.

MRI **NO YES** _____

_____

CT scan **NO YES** _____

_____

EEG (test for seizures) **NO YES** _____

_____

Check any of the following that the child's biological family members have had (include parents, siblings, grandparents, aunts, uncles and first cousins) Write the relationship on the line beside the illness.

☐ Asthma _____ ☐ Seizures _____ ☐ Depression _____

☐ Diabetes _____ ☐ Tuberculosis _____ ☐ High blood pressure _____

☐ Bipolar illness _____ ☐ Genetic disease _____ ☐ Anxiety _____

☐ Drug abuse _____ ☐ Alcohol abuse _____ ☐ High cholesterol _____

☐ Heart disease before the age of 35 (for example: sudden cardiac death or fainting (syncope). If yes, please describe in detail_____

_____

_____

List child's current medication/dosage, who prescribes them and why it is taken

Medication_____ Dose_____ Times_____ Doctor_____

Response _____ how long on med _____

Reason for med _____

Medication_____ Dose_____ Times _____Doctor_____

Response_____ how long on med_____

Reason for med_____

Medication_____ Dose_____ Times _____Doctor_____

Response_____ how long on med_____

Reason for med_____

Medication_____ Dose_____ Times _____Doctor_____

Response _____ how long on med_____

Reason for med _____

List any medications your child has taken in the past, when it was taken and why it was stopped

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

CHILD'S DEVELOPMENTAL HISTORY

Was pregnancy planned? **NO YES** Birth weight _____ Full term or early _____

Problems during pregnancy/birth? **NO YES**: _____

Any history of prenatal substance exposure? **NO YES**: _____

Any history of postpartum depression? **NO YES**: _____

History of miscarriages/abortions prior to this delivery? **NO YES**

_____

Birth - infancy

Any negative responses to separation from parents, feeding schedules, change? **NO YES** _____

_____

What was the parent/child relationship during infancy? _____

Any family changes/stressful events during this time?_____

Toddler years: (1 – 4 years old)

When did the child start walking? _____ talking? _____ toilet trained? _____

Any toilet training problems/regressions? **NO YES** _____

Any behavior or temperament problems? **NO YES** _____

_____

What age did you first notice problems in your child's behavior?_____

What was the parent/child relationship? _____

Any family changes/stressful events during this time?_____

Childhood years: (five – twelve years old)

What was the parent/child relationship? _____

Any family changes/stressful events during this time?_____

Describe child's strong points: _____

Did your child attend daycare? **NO YES** What ages did they attend?_____

Any behavior problems? **NO YES** _____

NEGLECT AND ABUSE HISTORY

Any history of physical abuse? **NO YES** _____

_____

_____

Any history of sexual abuse (including rape)? **NO YES** _____

_____

_____

Any history of neglect? **NO YES** _____

_____

Any exposure to violence (movies or domestic violence)? **NO YES**_____

_____

Has Social Services ever investigated the family or patient? **NO** **YES**

When?	Why?	Findings/Result of Investigation
1) _____	_____	_____
2) _____	_____	_____

EDUCATIONAL HISTORY

Current School _____Current grade_____ Last school grade completed _____

Name of primary school contact: _____

Type of educational disability if child is in special education

☐ LD (learning disability) grade started _____

☐ EBD (emotional behavioral disabled) grade started _____

☐ EMD (educable mentally disabled. IQ 50 – 70) grade started _____

☐ OHI (other health impairment) Reason_____ Example ADHD, bipolar disorder, medical conditions

When it started _____

Type of school classroom – please write when that placement started if other than a regular class

☐ Regular classroom education? _____

☐ Resource: How many periods per day? _____ When started?_____

☐ Self – contained class room - When started?

_____

Has your child had any educational testing other than testing all children receive (standardized)? **NO YES** If yes, then when and where?

_____

Special education services or 504 Plan? **NO YES** _____

Does the child have an I.E.P.? **NO YES** _____

Peer/Teacher Relations _____

Preferred Learning Method: **Visual** **Auditory** **Tactile**

Recent school performance (grades, behavior):_____

_____

_____

How frequently is your child sent to the principal's office? _____

How frequently are you called about your child's school behavior? _____

Has your child been suspended? **NO YES** _____

Has your child ever repeated a grade? **NO YES** _____

Number of days of school missed in past year? **0-5** **6-10** **11-15** **>15**

Past schools _____

_____

☐ Speech therapy When_____ Where_____

☐ PT (physical therapy) When_____ Where_____

☐ OT (Occupational therapy) When_____ Where_____

***If available - Please enclose a copy of the psychological testing results, IEP or 504 Plan.**

ENVIRONMENTAL AND CULTURAL FACTORS

Cultural and Spiritual Needs/Issues

Spiritual affiliation? _____

Active in cultural or spiritual activities? **NO YES:** _____

Cultural/environmental factors that may interfere with treatment? **NO YES:** _____

Leisure/Recreation Interests

What are the patient's interests/hobbies? _____

_____

Types of movies child likes to watch?_____

What kind of video games does your child like?_____

Hours of TV, video games, computer per week? **<10** **11-24** **>25**

Environmental Needs

Patient has stable housing? **YES NO:** _____

Neighborhood safe? **YES NO:** _____

Do you receive your drinking water from a private well? **YES NO** _____

Are guns stored in the house**? YES NO** Are they locked up? **YES NO**

Other environment concerns?_____

_____

Discharge Plans for after Residential Treatment: _____

_____

_____

Available Community Resources

Put a check mark beside the support systems or community resources you have available to you – even if you do not use them. Circle the ones that you use.

- ☐ Church
- ☐ Dept. of Social Services
- ☐ Extended family
- ☐ Big Brother/Big Sister
- ☐ Continuum of Care
- ☐ After school programs
- ☐ Probation
- ☐ Advocacy Group
- ☐ Autism Society
- ☐ Other
- ☐ Mental Health Services
- ☐ Neighborhood Community Center
- ☐ Neighbors
- ☐ Dept. of Disabilities & Special Needs
- ☐ Other

MEDICAL INSURANCE INFORMATON

Medicaid number_____

Primary insurance

Name of insurance company_____

Phone number_____ Group number_____

Policy holder_____ Relationship to child_____

Policy holder birth date_____ Policy holder SS # _____

Secondary insurance

Name of insurance company_____

Phone number_____ Group number_____

Policy holder_____ Relationship to child_____

Policy holder birth date_____ Policy holder SS # _____

PLEASE INCLUDE THE FOLLOWING INFORMATION

*A CURRENT PICTURE OF YOUR CHILD
*A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS
*A COPY OF CUSTODY PAPERS IF APPLICABLE

_____

Signature of Person completing this form/relationship to child **Date/Time**

Reviewing Nurses Signature **Date/Time**

Reviewing Physician Signature **Date/Time**

Reviewing Therapist Signature **Date/Time**

Reviewing Teacher Signature **Date/Time**