

Identification Label



**Mental Health Services
Psycho-Social Assessment – Child Services**

Client Name: _____ **DOB:** _____

Presenting Issues and Concerns: (from parent's, child's, other's perspective) _____

ASSESSMENT OF LIFE DOMAINS

Domain I - Family				
Family Members residing in the home				
Name	Sex	Age	Relationship	School/Employer

Family Members/Significant Others (not at home)				
Name	Sex	Age	Relationship	School/Employer

Comments: _____

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Domain IV – Assessment			
Biological Assessment:			
Sleep: <input type="checkbox"/> Normal <input type="checkbox"/> Excessive <input type="checkbox"/> Initial Insomnia <input type="checkbox"/> Intermittent Insomnia <input type="checkbox"/> Early waking <input type="checkbox"/> Nightmares	Appetite: <input type="checkbox"/> Normal <input type="checkbox"/> Excessive <input type="checkbox"/> Decreased If decreased or excessive, describe:	Weight: <input type="checkbox"/> Gain of: _____ lb/s Over what period of time: _____ <input type="checkbox"/> Loss of: _____ lb/s Over what period of time: _____	
Encopresis ? Yes No	Details:		
Enuresis ? Yes No			
Risk Assessment – History:			
Client has a history of:	Yes	No	Describe, give date of last event:
Suicidal Gestures/Attempts			
Aggressive Behaviors toward people, animals or self			
Self mutilating behaviors/gestures			
Restricting Food/Diagnosed as Anorexic			
Binging & Purging/Diagnosed as Bulimic			
Risk Taking Behaviors			
Criminal Activity			
Inappropriate Sexual Activities			
Comments:			

Last Psychological Examination ____/____/____ By: _____

Previous Psychiatric Hospitalizations: (name)	Where:

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Developmental History			
Significant developmental milestones or delays? (please comment)			
Pre Natal History			
Any complications during pregnancy? (please comment)			
Post Natal History			
During the first year were there:	Yes	No	Describe:
Any health problems at birth?			
Any serious health problems in the first year?			
Problems sleeping or eating?			
How does the parent describe the child during the first year?			
<input type="checkbox"/> Easy			<input type="checkbox"/> Difficult
<input type="checkbox"/> Happy and content			<input type="checkbox"/> Cried a lot
<input type="checkbox"/> Liked to be picked up			<input type="checkbox"/> Demanded attention
<input type="checkbox"/> Liked to be cuddled			<input type="checkbox"/> Would not be comforted or cuddled

Substance Use History: (check all that apply)

Family alcohol/drug abuse history:

- father stepparent/live-in
- mother uncle(s)/aunt(s)
- grandparent(s) spouse/significant other
- sibling(s) children
- other _____

Substance use status:

- no history of abuse
- active abuse
- early full remission
- early partial remission
- sustained full remission
- sustained partial remission

Treatment history:

- outpatient (age(s) _____)
 - inpatient (age(s) _____)
 - 12-step program (age(s) _____)
 - stopped on own (age(s) _____)
 - other (age(s) _____)
- describe: _____

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Substances used:

(complete all that apply)

	Current use				
	First Use age	Last Use Age	Yes/No	Frequency	Amount
<input type="checkbox"/> alcohol	_____	_____	_____	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____	_____
<input type="checkbox"/> barbiturates/owners	_____	_____	_____	_____	_____
<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____
<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> hallucinogens (e.g. LSD)	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (e.g. glue, gas)	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana or hashish	_____	_____	_____	_____	_____
<input type="checkbox"/> nicotine/cigarettes	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____	_____
<input type="checkbox"/> prescription _____	_____	_____	_____	_____	_____
<input type="checkbox"/> Opiates	_____	_____	_____	_____	_____

Consequences of substance abuse (check all that apply):

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> hangovers | <input type="checkbox"/> withdrawal symptoms | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> binges |
| <input type="checkbox"/> seizures | <input type="checkbox"/> medical conditions | <input type="checkbox"/> assaults | <input type="checkbox"/> job loss |
| <input type="checkbox"/> blackouts | <input type="checkbox"/> tolerance changes | <input type="checkbox"/> suicidal impulse | <input type="checkbox"/> arrests |
| <input type="checkbox"/> overdose | <input type="checkbox"/> loss of control amount used | | <input type="checkbox"/> relationship conflicts |
| <input type="checkbox"/> other _____ | | | |

Family Mental Health History			
Family member has been diagnosed with:	Yes	No	Relationship to client:
Depression			
Schizophrenia			
Anxiety or Panic Disorders			
Psychosis			
Attention Deficit Disorders			
Other			
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Client and Family History of Physical, Sexual and Emotional Abuse			
Self	Abuse	Family (relationship only)	Reported to:
	Emotional Abuse - Survivor		
	Emotional Abuse - Perpetrator		
	Physical Abuse – Survivor		
	Physical Abuse - Perpetrator		
	Sexual Abuse - Survivor		
	Sexual Abuse - Perpetrator		
Other Comments:			

Domain V – Social/Recreational Assessment:
Review formal and informal supports the client and or family utilize: (supports include social networks and friendships)
Review client's and/or family's perspectives of help givers:

Domain V – Legal
Review client's history with criminal and juvenile justice systems, police involvement, probation, legal needs, and issues involving custody:
Domain VI - Safety

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Current Risk Assessment			
Is/does the client currently:	Yes	No	Describe
Suicidal Ideation?			
Has a plan/intent?			
Has access to plan/means?			
Has a history of gestures/attempts?			
Homicidal ideation?			
Has a plan/intent?			
Has access to plan/means?			
Has a history of gestures/attempts?			
Has access to Firearms/Weapons?			
A current crisis plan is in place?			
Is likely to require crisis services?			
Review Safety of Client/family in home, pattern of crisis, coping skills, stress management, and a crisis plan:			

Domain VII – Education/Vocational Function Assessment:
Grade: _____ School: _____ Phone: _____
Education Programming: ____ Learning Disabilities ____ Behavioral Impairment ____ Regular Education ____ Special Education ____ Exceptional/Gifted Program
Academic Performance: ____ Above Average ____ At Grade ____ Below Average
____ IEP ____ 504 ____ SAT
Describe and Review Independent Living Skills / Employment / Adult Transition (as applicable):
Employment Type: _____ # of hours worked: _____/week
Comments:

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Empty rectangular box for identification or notes.

Domain VIII – Spiritual & Cultural:
Review family values, interests, rituals, traditions, spiritual and cultural connections:

Domain IX – Client Strengths and Barriers (including Physical and Environmental):

Domain X – Client Emotional, Psychiatric and Psychological Strengths and Needs:

Discharge Plan: _____

Signatures:

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

Clinical Supervisor: _____ **Date:** _____

Other Staff Involved: _____ **Date:** _____