LIST PSYCHOLOGICAL SERVICES, PLC
ADOLESCENT PSYCHOSOCIAL ASSESSMENT

CA BC Wilder LPR SAG Center BC Washington Huron

If parent is completing, please answer for the adolescent.

GENERAL INFORMATION:

Date: __________________ **Client Name**:____ Gender: ☐ M ☐ F
Age:___________ Birth Date:_________________________ With whom do you live?________________________
Mother's Full Name___________________________________ Custody? ☐ Physical ☐ Legal ☐ Visitation
Father's Full Name___________________________________ Custody? ☐ Physical ☐ Legal ☐ Visitation
Alternate Guardian___________________________________ Type of Guardianship? ☐ Relative ☐ Foster
*Did you bring a copy of the most recent court order regarding parenting time and custody? ☐ Yes ☐ No

Why are you seeking services at this time:____
____

FAMILY HISTORY:

- Who are you being raised by (check all that apply): ☐ Biological mother ☐ Biological father
  ☐ Stepmother ☐ Stepfather ☐ Other: ____
- How many brothers and sisters do you have? ____
- Briefly describe how you get along with others in your family (ie. Brothers, sisters, parents)_____________________
  ____
  ____
- Have you ever lived away from your parents? ☐ Yes ☐ No If yes, explain ________________________________
  ____
- Is there a history of mental illness in the family? ☐ Yes ☐ No If yes, who and what kind of problems?_________
  ____
- Have any family members committed suicide? ☐ No ☐ Yes, Who?_____________________________________
- Is there a history of drug and/or alcohol problems in the family? ☐ No ☐ Yes, who and what kind of substance?
  ____
- Please describe the family in which you were raised.____
- Do you identify with a particular ethnic group? ☐Yes ☐ No If yes, please name:______________________
- Do you identify with a particular religious group? ☐Yes ☐ No If yes, which one:______________________
- Have you experienced any difficulties related to your culture, ethnicity or religious affiliation? ☐ Yes ☐ No
  If yes, please explain:____

Are you aware of or do you suspect the child has experienced any of the following (please check all that apply):

___ Physical abuse
___ Neglectful home environment
___ Emotional abuse
___ Exposure to domestic violence
___ Exposure to other chronic violence
___ Sexual abuse or exposure
___ Parental substance abuse
___ Impaired parenting (mental illness)
___ Exposure to drug activity aside from parental use
___ Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
___ Lengthy or multiple separations from parent
___ Placement outside of the home (foster care, kinship care, residential)
___ Loss of significant people, places etc.
___ Frequent/multiple moves; homelessness
___ Other ________________________________

RELATIONSHIPS:

Present relationship status: ☐ Engaged ☐ Boyfriend ☐ Girlfriend ☐ No Significant Relationship

- If dating, how long with current partner? ____
- Are you currently or have you experienced any physical, emotional, or sexual abuse in your relationship(s)? If yes, please explain. ____
- How many children do you have? ______ What are their ages?____________________________
- Do you feel you have enough good friends? ☐ Yes ☐ No How many do you have?________________
- How easy do you make friends?____
- What issues with friends are currently concerning you or your child?__________________________

EDUCATION/EMPLOYMENT HISTORY:

- Current school(s) ______________________________ Grade level ______________________
- What are your current grades? ☐A's ☐B's ☐C's ☐D's ☐E's
- Are there any school attendance issues? ☐ Yes ☐ No If yes, explain.__________________________
- Have you ever had speech and language therapy? ☐ No ☐ Yes, where and when?___________________
  ____
- Check all that apply regarding your school experience: ☐ gifted classes ☐ special education ☐ school suspensions ☐ problems with classmates/bullying ☐ problems with teachers ☐ cheating ☐ extracurricular activities
- Do you have any learning problems? ☐ Yes ☐ No If yes, what are the problems? __________________
  ____
- Do you have a job? ☐ Yes ☐ No If yes, what is your job?______________________________
- Do you have any other sources of income? If yes, please list.☐ Yes ☐ No______________________
- Do you have any current job issues? ☐ Yes ☐ No ____________________________________
- Do you have problems with focus or attentiveness? ☐ Yes ☐ No
- Do you have problems staying seated? ☐ Yes ☐ No

DEVELOPMENTAL/MEDICAL HISTORY:

- Length of Mother's pregnancy for you? ☐ premature ☐ full-term ☐ post-term Birth weight_____________
- Were there any complications during pregnancy and/or during/after birth? (ie. Jaundice, head injury, etc)___________
  ____
- Did your Mother use substances during pregnancy? ☐ Yes ☐ No If yes, please list. ___________________
- Developmental Milestones (please list age when accomplished)? Crawl ______ Walk ________ Single word _____ 2 words+ _____ Bladder trained? day_____ night______ Bowel trained? day______ night________
- Has there been a history of bedwetting? ☐ Yes ☐ No If yes, explain; ______________________________
- Has there been a history of soiling? ☐ Yes ☐ No If yes, explain; ________________________________
- Hearing issues? ☐ Yes ☐ No If yes, explain____
- Vision issues? ☐ Yes ☐ No If yes, explain____
- Dental issues? ☐ Yes ☐ No If yes, explain____

- Medical Primary Care Physician: ______________________________ Date last seen: _____________
- How do you rate your general health? ☐ poor ☐ fair ☐ average ☐ good ☐ excellent
- Immunizations up to date? ☐ Yes ☐ No If no, explain?______________________________________
- What, if any, medical problems do you have (such as asthma, diabetes)?___________________________
  ____
- Are you currently taking medications? ☐ Yes ☐ No If yes, what medications?_____________________
  ____
- Drug allergies/adverse reactions/side effects____
  ____
- Do you have any concerns related to your weight?____
- Has your weight change over the last year? ☐ No ☐ Yes ☐ Lost _____lbs. ☐ Gained _____lbs.

- How many meals do you eat a day?_______Do you have any changes in eating habits/appetite? ☐ Yes ☐ No
  If yes, please describe: ____
- Do you currently participate in any type of exercise/physical activity? If yes, please describe: ____________________
  ____
- Caffeine Use: How many cups, cans or glasses of caffeinated beverages per day do you drink? __________________
- Do you currently use any tobacco products? If yes, describe____
- Have you had any head injuries or loss of consciousness? ☐ Yes ☐ No If yes, explain:___________________
  ____
- Have you had any surgeries? ☐ Yes ☐ No If yes, please list dates and what type:________________________
  ____
- Do you or have you ever struggled with eating issues such as binging, purging, compulsive overeating or going days without eating? If yes, please describe.____
  ____

PSYCHIATRIC HISTORY:

- Describe your personality (i.e. aggressive, calm, shy, high energy)____
- Have you been in counseling before? ☐ Yes ☐ No If yes, what type and when:___________________________
  ____
- Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No If yes, where and when:_________________
  ____
- Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you are affected in each area by circling the appropriate number (please circle only one number for each item).

NO PROBLEM	SOMEWHAT OF A PROBLEM	MODERATE PROBLEM	SERIOUS PROBLEM	SEVERE PROBLEM
#1	#2	#3	#4	#5

Item	Rating	Item	Rating
Depression (sadness, loss of interest, etc)	1 2 3 4 5	Sudden Change in mood	1 2 3 4 5
Anxiety (nervousness, panic, excessive worry)	1 2 3 4 5	Lack of energy	1 2 3 4 5
Anger control problems	1 2 3 4 5	Not liking self	1 2 3 4 5
Hallucinations (hearing voices/seeing things)	1 2 3 4 5	Not liking others	1 2 3 4 5
Thoughts of homicide	1 2 3 4 5	Withdrawal from others	1 2 3 4 5
Thoughts of suicide	1 2 3 4 5	*Problems with sleep	1 2 3 4 5
*Suicide attempts	1 2 3 4 5	Nightmares	1 2 3 4 5
*Obsessions or compulsions	1 2 3 4 5	Overly suspicious	1 2 3 4 5
*Serious trauma	1 2 3 4 5	Problems with boy/girlfriend	1 2 3 4 5
*Self-abusive behaviors	1 2 3 4 5	Problems with friends	1 2 3 4 5
Hyperactivity	1 2 3 4 5	Problems with gambling	1 2 3 4 5
Impulsivity	1 2 3 4 5		

*Explain ____
____
____

- Who do you rely on for support? (ie, spouse, parents, coworkers, etc) __________________________________

BEHAVIOR:

- Do you have concerns about your behavior? ☐ Yes ☐ No If yes, explain ______________________________
- Describe any changes in your behavior in the past year______________________________
- What disciplinary methods are commonly used and how effective are they? ______________________________
- Who usually disciplines you? ______________________________
- Are you using illegal substances or do your parents/guardian suspect you of this behavior? ☐ Yes ☐ No If yes, explain: ______________________________

Please complete the following regarding your drug/alcohol use history:

SUBSTANCES USED/ABUSED (such as alcohol, marijuana, vicodin, etc)	**AGE OF 1ST USE**	**YEARS OF USE**	**LAST DATE OF USE**	**AMOUNT USED**	**FREQUENCY OF USE**

What is your substance of preference?______________________________

Please answer the following questions:

☐ Yes ☐ No I have overdosed from drugs/alcohol.
☐ Yes ☐ No I have felt bad or guilty about my use of drugs/alcohol.
☐ Yes ☐ No Family members complain about my drug/alcohol use.
☐ Yes ☐ No My drug/alcohol use has created problems for my family.
☐ Yes ☐ No I lost friends because of my drug/alcohol use.
☐ Yes ☐ No I neglected my family because of my drug/alcohol use.
☐ Yes ☐ No I got in trouble at work/school because of my drug/alcohol use.
☐ Yes ☐ No I got in physical fights while under the influence of drugs/alcohol.

- Have you received treatment for a substance abuse problem before? ☐ Yes ☐ No If yes, explain______________________________
- Were you ever arrested, convicted or placed on probation? ☐ Yes ☐ No If yes, describe below:

  Age____________ Offense______________________________
  Age____________ Offense______________________________
- Are you currently on Probation/Parole? ☐ Yes ☐ No If yes, describe and give PO name:______________________________

______________________________ ______________________________

Parent/Guardian Signature **Date**