LIST PSYCHOLOGICAL SERVICES, PLC
CHILD PSYCHOSOCIAL ASSESSMENT

CA BC Wilder LPR SAG Center BC Washington Huron

If parent is completing, please answer for the child.

GENERAL INFORMATION:

Date: _____ **Client Name**:_____ Gender: ☐ M ☐ F
Age:_____ Birth Date:_____ Whom does the child live with?_____
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 for your child at this time:_____
_____

FAMILY HISTORY:

- Who is the child being raised by (check all that apply): ☐ Biological mother ☐ Biological father ☐ Stepmother ☐ Stepfather ☐ Other: _____
- How many brothers and sisters does your child have? _____
- Briefly describe how your child gets along with others in your family (ie. Brothers, sisters, parents)_____
  _____
  _____
- Has your child ever lived away from 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?
  _____
- Describe the family in which the child is being raised._____
- Does your child identify with a particular ethnic group? ☐Yes ☐ No If yes, please name:_____
- Does your child identify with a particular religious group? ☐Yes ☐ No If yes, which one:_____
- Has your child experienced any difficulties related to their 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 _____

EDUCATION/EMPLOYMENT HISTORY:

- Current school(s) _____ Grade level _____
- What are your child's current grades? ☐A's ☐B's ☐C's ☐D's ☐E's
- Are there any school attendance issues? ☐ Yes ☐ No If yes, explain._____
- Has your child ever had speech and language therapy? ☐ No ☐ Yes, where and when?_____
  _____
- Check all that apply regarding school experience: ☐ gifted classes ☐ special education ☐ school suspensions ☐ problems with classmates/bullying ☐ problems with teachers ☐ cheating ☐ extracurricular activities
- Does your child have any learning problems? ☐ Yes ☐ No If yes, what are the problems? _____
  _____
- Does your child have problems with focus or attentiveness? ☐ Yes ☐ No
- Does your child have problems staying seated? ☐ Yes ☐ No

BEHAVIOR:

- Do you have concerns about your child's behavior? ☐ Yes ☐ No If yes, explain _____
  _____
- Describe any changes in your child's behavior in the past year_____
  _____
- What disciplinary methods are commonly used and how effective are they? _____
  _____
- Who usually disciplines your child? _____

DEVELOPMENTAL/MEDICAL HISTORY:

- Length of Mother's pregnancy for the child? ☐ premature ☐ full-term ☐ post-term Birth weight_____
- Were there any complications during pregnancy and/or during/after birth? (ie. Jaundice, head injury, etc)_____
  _____
- Did 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 would you rate the child's general health? ☐ poor ☐ fair ☐ average ☐ good ☐ excellent
- Immunizations up to date? ☐ Yes ☐ No If no, explain?_____
- What, if any, medical problems does the child have (such as asthma, diabetes)?_____
  _____
- Is the child currently taking medications? ☐ Yes ☐ No If yes, what medications?_____
  _____
- Drug allergies/adverse reactions/side effects_____
  _____
- Are there any concerns related to your child's weight?_____
- Has child's weight change over the last year? ☐ No ☐ Yes ☐ Lost _____lbs. ☐ Gained _____lbs.
- How many meals does your child eat a day?_____
- Are there any changes in the child's eating habits/appetite? ☐ Yes ☐ No If yes, please describe: _____
  _____

- Does your child 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 does your child drink? _____
- Has your child had any head injuries or loss of consciousness? ☐ Yes ☐ No If yes, explain:_____
_____
- Has your child had any surgeries? ☐ Yes ☐ No If yes, please list dates and what type:_____
_____
- Is your child or has your child ever struggled with eating issues such as binging, purging, compulsive overeating or going days without eating? If yes, please describe._____
_____

PSYCHIATRIC HISTORY:

- Describe your child's personality (i.e. aggressive, calm, shy, high energy)_____
- Has your child been in counseling before? ☐ Yes ☐ No If yes, what type and when:_____
_____
- Has your child 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 your child is affected in each area by circling the appropriate number (please circle only one number for each item).

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

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 friends	1	2	3	4	5
*Self-abusive behaviors	1	2	3	4	5	Impulsivity	1	2	3	4	5
Hyperactivity	1	2	3	4	5						

*Explain _____

_____

_____

- Who does your child rely on for support? (ie, spouse, parents, teachers, etc) _____

_____ _____

Parent/Guardian Signature **Date**