# Assessment - Youth Report

## Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chart No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_ Age:** \_\_\_\_\_\_\_\_

**General Background**

**1. Briefly explain why you are seeking treatment for your child**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. How long has this been a problem?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. What have you done to try and correct the problem up to this point?**

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**4. Has your child ever been in counseling before (mental health, chemical dependency or hospitalizations)?** ** No  Yes**: If yes please explain.

Mental Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemical Dependency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Who lives in the household and what is their relationship to your child?**

Name Age Relationship to your child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**6. Who is primarily responsible for the care of your child? List all that apply.**

Name Age Relationship to your child

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**7. What are the most common disciplinary techniques used in the household?** (Verbal reprimands, yelling, ignoring, time-out, grounding, removal of privileges, spanking, etc.)

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**8. Are discipline techniques used consistently and with good follow-through?**

** No  Yes**

**9. Are current disciplinary techniques effective at controlling undesirable behaviors?**

** No  Yes**

**10. Does your child respond to one parent or care-taker’s disciplinary measures better than an other?**

** No  Yes:** If yes, who\_\_\_\_\_\_\_\_\_\_

**11. Has your child experienced any of the following?**

**** Parental Divorce **** Parental Separation **** Death of a Parent

**** Death of a Sibling **** Death of a Grandparent **** Death of a Close Friend

**** Financial Problems **** Parental Alcoholism **** Parental Drug Abuse

**** Domestic Violence **** Physical Abuse **** Verbal Abuse

**** Sexual Abuse **** Family Bankruptcy **** Prolonged Marital Discord

**12. Has any member of your family ever been diagnosed with a mental illness or substance abuse problem including alcoholism.** (This would include extended family such as grandparents and aunts and uncles.)

** No  Yes:** If yes, please provide further details.

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**13. Was your child born premature?**

** No  Yes:** If yes, please provide details. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**14. Birth Weight:** \_\_\_\_\_\_\_\_\_ lbs. \_\_\_\_\_\_\_\_\_oz.

**15. Approximately what age did your child first begin the following:**

Walking \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Talking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Toileting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History

**16. Does your child have any immediate health problems (colds, injuries)?**

** No  Yes:** If yes, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**17. Does your child have any chronic (longer-term) health problems (asthma, seizures, allergies, pain)?**

** No  Yes:** If yes, please explain.

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**18. Does your child have any developmental disorders (mental retardation, learning disabilities, hearing disabilities, speech problems, etc.)?**

** No  Yes:** If yes, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**19. Has your child ever sustained any serious head injuries (been knocked unconscious, been in a car accident, fight, etc.)?**

** No  Yes:** If yes, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**20. Is your child currently under the care of a physician?**

** No  Yes:** If yes, who and for what conditions.

Doctors Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Conditions being treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**21. Is your child currently on any medications?**

** No  Yes:** If yes, please list:

Medication Dosage Date Started

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**22. Please list all previous mental health medications:**

Medication Dosage Date Started Date Stopped

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**23. Please rate the nutritional value of your child’s total daily diet intake. Good \_\_ Fair \_\_ Poor \_\_**

If Fair or Poor, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following that apply.

**** Significant weight gain/loss in the last six months **** Problems chewing or swallowing

**** Food/drug allergies **** Dieting

**** Overeating or eating too little

If any box is checked please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**24. Does your child have any functional limitations that affect daily living (e.g. physical impairments, problems with self-care or grooming)? Yes \_\_\_ No \_\_\_**

If Yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**25. Has your child had a recent vision exam?**

** No  Yes:** If yes, please describe results. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**26. Has your child had a recent hearing exam?**

** No  Yes:** If yes, please describe results. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational History

**27. What grade is your child currently in?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**28. Where does your child attend school?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**29. Circle any grade(s) failed.** K 1 2 3 4 5 6 7 8 9 10 11 12 None N/A

**30. Circle any grade(s) skipped.** K 1 2 3 4 5 6 7 8 9 10 11 12 None N/A

**31. What grades does your child normally get in school?** (Circle all that apply)

A B C D F

**32. Have there been any tendencies toward improving or deteriorating school performance over the years?**

** No  Yes:** If yes, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**33. What are your child’s strongest subjects in school?** (Circle all that apply)

Math History English Reading Spelling Science Social Studies N/A

**34. What are your child’s weakest subjects in school?** (Circle all that apply)

Math History English Reading Spelling Science Social Studies N/A

**36. Has your child ever been:**

**Reprimanded at school:  No  Yes**

**Served detention:** ** No  Yes**

**Been suspended:** ** No  Yes**

**Been expelled:** ** No  Yes**

**If Yes was checked, please explain why\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**37. Has the school ever performed psychological or educational testing with your child?**

** No  Yes:** If yes, why and what was the outcome.

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Social Development

**38. Does your child have many friends?**

** No  Yes**

**39. Does your child make friends easily?**

** No  Yes**

**40. What are the most common activities that your child engages in?** (Bike riding, playing with friends, watching T.V., etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Behavioral Assessment

**41. Has your child ever been in trouble with the legal authorities?**

** No  Yes:** If yes, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**42. To your knowledge, does your child use tobacco?**

** No  Yes:** If yes, how often, how much and for how long?

**43. To your knowledge, does your child drink alcohol?**

** No  Yes:** If yes, how often, how much and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many drinks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**44. What problems has your child suffered as a result of his/her drinking? (Check all that apply.)**

**** Arrest **** DUI **** Peer Problems

**** Public Intoxication **** Financial Problems **** Arguments

**** None of the Above

**45. To your knowledge, has your child ever tried any drugs?**

** No  Yes:** If yes, what drug?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**46. To your knowledge, does your child use any drugs?**

** No  Yes:** If yes, how often and for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What drug was used and how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**47. Which of the following drugs has your child used in the last 6 months?**

**** Marijuana / “Pot” **** Cocaine **** Pain Killers

**** LSD / “Acid” **** Amphetamines / “Speed” **** Sedatives / “Downers”

**** Inhalants / “huffing” **** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **** None of the Above

**48. To your knowledge, is your child sexually active?**

** No  Yes**

**49. Does your child have concerns about his/her sexual orientation or sexual experiences?**

** No  Yes**

**50. Is your child pregnant or the parent of a child?**

** No  Yes:** If yes, please provide further details.

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**51. Who has legal custody of your child?**

**** Both Parents **** Mother only **** Father only **** Other guardian

If Other guardian, please indicate name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assessment - Youth**

## Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chart No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**YOUTH SYMPTOM CHECK LIST:**

0) None:

1) Mild: Some Times/Some Concern/Brief Episode

2) Moderate: Often/Significant Worry/Lasts for a While

3) Severe: Very Often/High Intensity/Continuous

|  |  |
| --- | --- |
|  |  |
| Rather be alone |  |
| Refuses to talk |  |
| Secretive |  |
| Shy, Timid |  |
| Irritable |  |
| Sulks |  |
| Underactive |  |
| Sad |  |
| Lonely |  |
| Cries a Lot |  |
| Fears Going to School |  |
| Needs to be Perfect |  |
| Feels Unloved |  |
| Feels Picked On |  |
| Feels Worthless |  |
| Nervous, Tense |  |
| Fears Animals, Places, Situations |  |
| Anxious |  |
| Self Conscious |  |
| Worries |  |
| Over Conforms |  |
| Feelings Easily Hurt |  |
| Anxious To Please |  |
| Afraid to Make Mistakes |  |
| Trouble With Sleep |  |
| Anxious if Separated from Parents |  |
| Nightmares |  |
| Failure to Speak in Some Settings Situations |  |
| Changes/Problems with Eating |  |
| **II** |  |
| Feels Dizzy |  |
| Overtired |  |
| Aches, Pains |  |
| Headaches |  |
| Nausea |  |
| Rashes |  |
| Stomachaches |  |
| Vomiting |  |
| Wets Self Day or Night |  |
| BM Accidents or Smears BM |  |
| **III** |  |
| Acts too Young |  |
| Too Dependent |  |
| Poor Peer Relations |  |
| Gets Teased |  |
| Clumsy |  |
| Prefers Younger Children |  |
| Overweight |  |
| Accident Prone |  |
| **IV** |  |
| Concentration Problems |  |
| Difficulty Sitting Still |  |
| Restless |  |
| Energetic |  |
| Talks Excessively |  |
| Difficulty Waiting Turn |  |
| Interrupts Others |  |
| Looses Things |  |
| Easily Distracted |  |
| Forgetful |  |
| Daydreams |  |
| Impulsive |  |
| Fidgets |  |
| Difficulty Following Directions |  |
| Messy Work |  |
| Makes Careless Mistakes |  |
| Poor Listening Skills |  |
| Poor Organizational Skills |  |
| Twitches |  |
| Hums, Odd Noises |  |
| **V** |  |
| Can’t Get Mind Off Thoughts |  |
| Hears Things |  |
| Sees Things |  |
| Repeats Acts |  |
| Strange Behaviors |  |
| Strange Ideas |  |
| **VI** |  |
| Argues |  |
| Brags |  |
| Mean to Others |  |
| Demands Attention |  |
| Destroys Own/Other’s Things |  |
| Disobedient at School |  |
| Disobedient at Home |  |
| Jealous |  |
| Fights |  |
| Attacks People |  |
| Screams |  |
| Shows Off |  |
| Stubborn |  |
| Easily frustrated |  |
| Sudden Mood Changes |  |
| Temper Tantrums |  |
| Threatens |  |
| Disturbs Others |  |
| Disrupts Class |  |
| Explosive |  |
| **VII** |  |
|  |  |
| Lacks Guilt |  |
| Bad Peer Group |  |
| Lies |  |
| Prefers Older Kids |  |
| Runs Away |  |
| Sets Fires |  |
| Steals |  |
| Swearing/Obscenity |  |
| Skips School |  |
| Alcohol Use |  |
| Drug Use |  |
| Vandalism |  |
| Too Sexual |  |
| **VIII** |  |
| Talks About Killing Self |  |
| Past Suicide Attempts |  |
| Hits/Hurts Self |  |
| Talks About Hurting Others |  |
| Hits/Hurts Others |  |
| Hurts Animals |  |
| Other: |  |
| Other: |  |
| Other: |  |
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