Demographics & Life Status

Child's Name: _____ Pronouns: _____

Parent/Guardian Phone:(_____)_____ Parent/Guardian Email: _____

Address: _____ City, State, Zip Code: _____

Age: _____ DOB: _____ /_____ /_____ Place of birth: _____

Sex: _____ (Assigned female at birth, assigned male at birth, intersex, etc.)

Gender: _____(Cisgender, Transgender, Non-binary, Gender diverse, etc.)

Race: _____ (ex. African American, Asian, Black, Caucasian, Hispanic, etc.)

How is your child related to you (biologically, adoption, foster care, etc): _____

Parent/Guardian Marital Status: Single __ Married __ Partnered __ Divorced __ Widowed __ Separated __ Other

Who does your child live with?_____

Any other important adults in the child's life? _____

Referral source: How did you find us?_____

Emergency Contact - Name: _____ Phone: (_____)_____

Cultural, religious, spiritual influences/considerations (community, arts, beliefs, celebrations, customs, traditions):

_____

Describe child's current economic situation/basic needs: _____

Child's Education History

_____

_____

Any history of school avoidance/truancy? _____

Are there any IEP/504 plans in place or disability services used?_____

Significant Personal Relationships/Family

Describe your child's significant relationships, supportive or not (immediate & extended family, friends, etc.):

_____

_____

_____

Identified Family Name(s)/ Age/ Living: Yes / No

Father: _____

Mother: _____

Siblings/Pets: _____

Others: _____

Strengths, Activities, Resources & Support Systems

List some of your child's strengths: _____

_____

Child's activities/hobbies: _____

_____

# of hours/week engaged in leisure activities outside of the home: _____

What helps your child get through each day? What resources do they have in life? _____

_____

_____

Mental & Physical Health Status

Any current psychiatric diagnosis, or suspected diagnosis: _____

_____

Has your child ever had psychological testing done for mental health or learning disabilities? _____

Any other mental health struggles or other conditions you or your child has concerns about? _____

_____

How do these things affect your child's current daily functioning? _____

_____

Does your child have any sensory sensitivities or needs/accommodations? _____

Child Symptom Checklist - Use checkmark - **_ for CURRENT symptoms** & an asterisk - *** for PAST symptoms:**

- ❑ Anxiety
- ❑ Panic Attack
- ❑ Depressed Mood
- ❑ Decreased Concentration
- ❑ Decreased Energy
- ❑ Executive Dysfunction
- ❑ Irritability
- ❑ Hyperactivity
- ❑ Hopelessness
- ❑ Tearfulness
- ❑ Guilt
- ❑ Grief
- ❑ Somatic issues
- ❑ Flashbacks/Night Terrors
- ❑ Dissociation
- ❑ Memory Problems
- ❑ Mood Swings/Lability
- ❑ Mania/Hypomania
- ❑ Insomnia/Hypersomnia
- ❑ Impulsivity
- ❑ Obsessions/Compulsions
- ❑ Intrusive/Ruminating Thoughts
- ❑ Paranoia
- ❑ Delusions
- ❑ Hallucinations
- ❑ Phobia(s)
- ❑ Overwhelm
- ❑ Meltdowns
- ❑ Sensory Issues
- ❑ Somatic Issues
- ❑ Other symptoms not listed: _____

What are your (as the parent/guardian) goals & needs when it comes to your child's mental health support? __

_____

_____

What are your child's goals for mental health support? _____

List current providers / treatment (primary care doctor, nurse, psychiatrist, therapist, social worker, ARMHS, PCA, school social worker, other): _____

_____

_____

Current medications: _____

_____

Provider of medications: _____

List past therapeutic, psychiatric, & psychiatric hospitalization treatment, including names of providers & dates:

_____

_____

_____

Describe current or past physical, emotional, or sexual abuse experienced and/or witnessed :

_____

_____

_____

_____

_____

For Mental Health Professional only: If necessary, reports made to Adult or Child Protection: □

Other significant issues, stressors, or milestones in infancy or childhood: _____

_____

_____

_____

Was the child's pregnancy/birth typical (if known)? _____

Other significant issues, stressors, or milestones:: _____

_____

_____

_____

Significant deaths & dates (including pets): _____

Legal issues:: _____

Self esteem issues: _____

_____

Social concerns: _____

_____

Has your child had suicidal thoughts or attempts? If so, please describe: _____

_____

_____

_____

For Mental Health Professional only:
Current Suicide Risk Assessment: □ low □ moderate □ high - If necessary, Referrals Made or APS contacted: □

Describe any current family mental health issues and family substance abuse. Include history: _____

_____

_____

_____

_____

Child chemical use/dependency - How often, to your knowledge, does your child use alcohol, drugs, or cigarettes?

_____

List current and previous medical problems and treatments: _____

_____

_____

_____

List family medical history/issues: _____

_____

_____

Signature **Date**

_____

For Mental Health Professional only:

*Releases obtained & sent for Current/Past assessments & treatment plans □

WHODAS given at DA session □

Completed other Assessment tools (As need be):

Beck Depression □ Beck Anxiety □ Further CD Assessment □ Other □_____

Reviewed previously administered psychological assessments as listed with results and dates noted:

_____

Mental Health Practitioner who reviewed this form, **Print, Sign, & Date**

_____

Licensed Mental Health Professional, (if different than above) **Print, Sign, & Date**

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