



CONNECTIONS THERAPY CENTER

Child Assessment

Dr. Cindy Stear, PsyD and Associates

815-957-0115

drcindystear@connectionstherapycenter.com

Date: _____ Child's Name: _____ Birthdate: _____ Age: _____ Gender: _____

Weight: _____ Height: _____ Ethnicity: _____ Race: _____

Child's Residence: _____

Child's Telephone #: _____ Who has custody of child? _____

Who does the child reside with? _____ Who will accompany the child to counseling? _____

Mother's Name: _____ Birthdate: _____ Age: _____

Mother's Address: _____

Mother's Home #: _____ Work #: _____ Cell #: _____

Mother's Marital Status: _____ Step-Parent/Mother's Partner: _____

Mother's Employer: _____

Mother's Highest Education Level: _____

Father's Name: _____ Birthdate: _____ Age: _____

Father's Address: _____

Father's Marital Status: _____ Step-Parent/Father's Partner: _____

Father's Employer: _____

Father's Highest Education Level: _____

PRESENTING PROBLEM

What do you feel is the major problem? _____

How long have these problems persisted? _____

Under what conditions do the problems usually get worse? _____

Under what conditions do the problems usually improve? _____

What does the other parent feel is the major problem? _____

What does the school believe to be the problem? _____

Do you know of any events in your child's life associated with current problems? Yes No

If yes, please explain: _____

Is there any history of any genetic disorders in the family? _____

Does anyone in the child's family (i.e., mother, father, siblings, grandparents, aunts, uncles, cousins) suffer from depression, anxiety, mood swings, psychosis, nervous breakdowns, or other emotional problems?

Yes No if yes, please explain: _____

Has any family member had a language or speech problem? _____

CHILD'S FAMILY HISTORY

Was the child adopted or raised with parents other than the natural parents? Yes No

If yes, please describe the relationship (if any) with the child's biological parents or guardians: _____

If parents are separated or divorced, how old was the child at the time? _____

If parents are separated or divorced, briefly explain the reason: _____

If parents are separated or divorced, what was the impact on the child? _____

If parents are separated or divorced, please describe visitation arrangements (if any): _____

This child was child number _____ in a family of _____ children # of brothers _____ # of sisters _____

Siblings Name & Age _____

Briefly describe the style of parenting, including rewards and discipline used in household: _____

What behaviors concern you? _____

When your child misbehaves, how do you respond? _____

How does the other parent respond? _____

CHILD'S MEDICAL HISTORY

Pediatrician/Physician's Name: _____ Phone #: _____

Address: _____

Recent physical exam: _____ Results: _____

Last eye exam: _____ Results: _____

Has had their hearing tested: _____ Results: _____

Check all that have applied to this child:

High Fever 104 _____	Ear infections before 2 yrs _____	Ear infections after 2 yrs _____
Tubes inserted _____	Fainting _____	Stomach Aches _____
Asthma _____	Seizures _____	Colds _____
Chronic Illness _____	Allergies _____	

Has your child ever been hospitalized? Yes No Please explain: _____

Does your child have difficulty with any of the following?

Sucking _____ Swallowing _____ Chewing _____ Sleeping _____ Eating solid foods _____

At what age did your child?

Sit alone _____ Babble _____ Crawl _____ Walk alone _____ Stop drooling _____
Say 3-6 different words _____ Combine words _____ Day toilet train _____ Night toilet train _____
Dress self _____ Sleep through the night _____

Check all that apply to your child's infant behavior:

Frequently smiled _____	Frequently cried (no cause) _____	Cried when wet _____
Cried when hungry _____	Easy to soothe _____	Difficult to soothe _____
Enjoyed being held _____	Enjoyed being rocked _____	Adapted to new things _____
Difficulty adapting to new things _____		

PHYSICAL GROWTH

At what age did your child have his/her major growth spurt? _____

Age of puberty: _____

List any major illnesses and/or operations: _____

List any physical concerns occurring at present (i.e., headaches, bed wetting, elimination problems, aches/pains, illnesses, etc.): _____

Any allergies to foods or medications: _____

Average number of hours of sleep your child receives per night: _____

Does your child have trouble falling asleep, experience nightmares and/or have other sleep problems?

Yes No Please explain & how long has this been a problem: _____

CHILD'S EDUCATIONAL HISTORY

Name of child's school: _____

Grade Level: _____ Is the child in Special Education or specialized schooling: Yes No

Please explain: _____

Briefly describe your child's performance in school: _____

Has your child ever received a psychological evaluation? Yes No

By whom & for what reason: _____

Is your child seeing a school counselor/psychologist? Yes No

Please provide their name & telephone number: _____

Previous schools attended, include nursery and daycare: _____

Has your child ever repeated any grade? Yes No Which grade? _____

Has your child been on probation? Yes No How many times? _____

Has your child been suspended? Yes No Has your child been expelled? Yes No

In what academic areas is your child experiencing success? _____

In what academic areas is your child experiencing failure? _____

Achieving academic success _____ Borderline success _____ Not experiencing success _____

CHILD'S SOCIAL HISTORY

When interacting with peers, your child may generally be described as: (check all that apply)

Follower Loner Friendly Shy Aggressive Submissive Assertive Withdrawn Disinterested

Accepted member of a group Rejected by group Uninterested in becoming part of a group

Give a brief description of your child's relationship with:

Mother: _____

Father: _____

Sibling(s): _____

Briefly describe your child's hobbies and interests: _____

CHILD'S LEISURE HISTORY

What type of leisure time activities does your child enjoy? _____

How does your child spend most of their play time? _____

Play alone _____ Playing with siblings _____ Playing with adults _____ Playing with peers _____

On an average, how much time does your child spend on game systems (i.e., DS, Xbox, Cube, Wii, PSP)? _____

On an average, how much TV does your child watch daily? _____

What kind of programs does your child enjoy? _____

Delay in Speech? Yes No Is your child's speech better in some situations than others? Yes No

Please explain: _____

Does your child shy away from speaking, such as story telling or show and tell? Yes No

BEHAVIORS OF CONCERN Please check how often behaviors occur.

Loses temper easily	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Argues with adults	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Refuses adults' requests	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Deliberately annoys people	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Blames others for own mistakes	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Easily annoyed by others	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Angry/resentful	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Spiteful/vindictive	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently

Defiant	___ Never	___ Rarely	___ Sometimes	___ Frequently
Bullies/teases others	___ Never	___ Rarely	___ Sometimes	___ Frequently
Initiates fights	___ Never	___ Rarely	___ Sometimes	___ Frequently
Uses a weapon	___ Never	___ Rarely	___ Sometimes	___ Frequently
Physically cruel to people	___ Never	___ Rarely	___ Sometimes	___ Frequently
Physically cruel to animals	___ Never	___ Rarely	___ Sometimes	___ Frequently
Stealing	___ Never	___ Rarely	___ Sometimes	___ Frequently
Forced sexual activity	___ Never	___ Rarely	___ Sometimes	___ Frequently
Intentional arson	___ Never	___ Rarely	___ Sometimes	___ Frequently
Burglary	___ Never	___ Rarely	___ Sometimes	___ Frequently
“Cons” other people	___ Never	___ Rarely	___ Sometimes	___ Frequently
Runs away from home	___ Never	___ Rarely	___ Sometimes	___ Frequently
Truant at school	___ Never	___ Rarely	___ Sometimes	___ Frequently
Doesn't pay attention to details	___ Never	___ Rarely	___ Sometimes	___ Frequently
Several careless mistakes	___ Never	___ Rarely	___ Sometimes	___ Frequently
Does not listen when spoken to	___ Never	___ Rarely	___ Sometimes	___ Frequently
Doesn't finish chores/homework	___ Never	___ Rarely	___ Sometimes	___ Frequently
Difficulty organizing tasks	___ Never	___ Rarely	___ Sometimes	___ Frequently
Loses things	___ Never	___ Rarely	___ Sometimes	___ Frequently
Easily distracted	___ Never	___ Rarely	___ Sometimes	___ Frequently
Forgetful in daily activities	___ Never	___ Rarely	___ Sometimes	___ Frequently
Fidgety/squirmy	___ Never	___ Rarely	___ Sometimes	___ Frequently
Difficulty remaining seated	___ Never	___ Rarely	___ Sometimes	___ Frequently
Runs/climbs around excessively	___ Never	___ Rarely	___ Sometimes	___ Frequently
Difficulty playing quietly	___ Never	___ Rarely	___ Sometimes	___ Frequently
Hyperactive	___ Never	___ Rarely	___ Sometimes	___ Frequently
Difficulty awaiting turn	___ Never	___ Rarely	___ Sometimes	___ Frequently
Interrupts others	___ Never	___ Rarely	___ Sometimes	___ Frequently
Problems pronouncing words	___ Never	___ Rarely	___ Sometimes	___ Frequently
Poor grades in school	___ Never	___ Rarely	___ Sometimes	___ Frequently
Expelled from school	___ Never	___ Rarely	___ Sometimes	___ Frequently
Drug abuse	___ Never	___ Rarely	___ Sometimes	___ Frequently
Alcohol consumption	___ Never	___ Rarely	___ Sometimes	___ Frequently
Depression	___ Never	___ Rarely	___ Sometimes	___ Frequently
Shy/avoidant/withdrawn	___ Never	___ Rarely	___ Sometimes	___ Frequently
Suicidal threats/attempts	___ Never	___ Rarely	___ Sometimes	___ Frequently
Fatigued	___ Never	___ Rarely	___ Sometimes	___ Frequently
Anxious/nervous	___ Never	___ Rarely	___ Sometimes	___ Frequently
Excessive worrying	___ Never	___ Rarely	___ Sometimes	___ Frequently
Sleep disturbance	___ Never	___ Rarely	___ Sometimes	___ Frequently
Panic attacks	___ Never	___ Rarely	___ Sometimes	___ Frequently
Mood shifts	___ Never	___ Rarely	___ Sometimes	___ Frequently
Inappropriate sexual behavior	___ Never	___ Rarely	___ Sometimes	___ Frequently
Lying	___ Never	___ Rarely	___ Sometimes	___ Frequently

For each of the behaviors noted as occurring *frequently*, or if it causes significant impairment, write a description of how it impacts the child's or other people's lives. Give examples.

BEHAVIORS OF CONCERN

IMPACT ON CHILD OR OTHERS

Is the child involved with any legal trouble or on probation? Yes No Please explain: _____

Briefly describe the child's way of expressing the following emotions or behaviors:

- Anger: _____
- Happiness: _____
- Sadness: _____
- Anxiety: _____

Additional information you believe will be helpful: _____
