FREEDOM Behavioral Health Services
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COMPREHENSIVE CLINICAL ASSESSMENT & INTAKE – Child/Adolescent

Child's Name _____ DOB _____ Date _____
Medicaid # _____ County _____ Chart # _____
Gender: __M __F Ethnicity: __White; __ Black; __ Biracial; __ Hispanic; __ Asian; __ Other
Sexual Orientation: _____ Gender Identity: _____
Individuals participating in assessment:

Current Treatment Focus

What brings you and your child to our office today? _____
_____
_____
_____

What services are you seeking:

___ Individual Therapy ___ Psychological/Educational Testing
___ Family Therapy ___ Psychiatric Services or Medication Management
___ Other (explain): _____

I/we would like to address the following: (check all that apply)

___ My child's mood or emotional state
___ My child's behavior
___ My child's school performance
___ My child's sleep, eating, or physical concerns
___ My child's cognitive/mental functioning
___ My child's relationships with family or peers
___ Parenting
___ Family relationships
___ Communication skills
___ Addictive behaviors
___ Social skills
___ Anger management/conflict resolution
___ Divorce
___ Other: _____
___ Abuse or neglect
___ Risk taking/self-harm behaviors
___ Acting out behaviors Describe: _____

Responsible Party Information

Responsible Party Name _____
Relationship to client _____
What is the best way to contact responsible party? _____
Current custody status: ___ Parents ___ Sole Parental Custody ___ Joint Legal Custody
___ DSS Custody ___ Other: _____

List all persons who may be bringing this child to therapy sessions _____
_____

Household Information

Client's current living situation:

___ At home with parents/guardians Number of parents in household _____
___ With other family
___ Foster care
___ Residential placement
___ Other (explain) _____

Has child experienced divorce/separation of parents/guardians? ___No ___ Yes

If yes, describe custody/visitation arrangements _____

Please list all members of the household:

Name	Relationship to Client	Gender	Age
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___

Please list any other significant family members who do not live with client: _____

Please list any members of household who have left the household in the past 6 months (include relationship, gender, age and reason for change)_____

_____
_____
_____
_____

School Information

School Name _____

Teacher Name(s) _____

Grade Level _____ Academic Performance: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing

Attendance: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing

Behavior in school: ___ Excellent; ___ Good; ___ Fair; ___ Poor; ___ Failing

IEP in place? ___ No ___ Yes (explain:) _____

Has child been retained? __ No __Yes Explain: _____

Has child been subject of bullying? __ No ___ Yes Explain: _____

Has child been involved in bullying? __ No ___ Yes Explain: _____

Developmental History

Was your child: ___ Planned ___ Breast Fed ___ In Day Care
___ Unplanned ___ Bottle Fed ___ Kept at Home
___ Exposed to medications/drugs/alcohol in the womb
___ Difficult or high-risk pregnancy or delivery

At what age did your child: Talk _____ Walk _____ Potty Train _____

Describe any developmental delays _____

_____

Medical History Has your child experienced any of the following? (please explain)

___ Childhood trauma (Explain) _____
__Witness/experience domestic violence _____
__Witness/experience alcohol/substance abuse _____
__ Witness/experience physical abuse_____
__ Witness/experience sexual abuse _____
__ Witness/experience emotional abuse_____
__Witness/experience verbal abuse _____

___ Severe illness, injury, surgery _____
___ Allergies (foods, drugs, substances) _____
___ Chronic medical problems _____
___ Significant family medical history _____
___ Significant family mental health history _____
___ Prior mental health diagnosis _____
___ Prior developmental diagnosis _____

Primary care physician _____

Current medications Name Dosage

_____ _____
_____ _____
_____ _____

Past medications Name Dosage Time period used Reason for termination

_____
_____
_____
_____
_____
_____

Treatment History

Please list all mental health treatment or hospitalizations

Facility/Therapist	Purpose	Current	Past
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Response to Treatment: _____

Other agency/service involvement in past 6 months:

___ Child Protective Services ___ Justice System ____ Physical therapy
___ Other DSS Services ___ Disability/Social Security ___ Other: _____
___ Occupational Therapy ___ Speech therapy ___ Other _____

Social/Family Information

Religious preference _____

Involved in local church? ___ No ___ Yes: _____

Family values and important beliefs: _____

_____

Normal bedtime: _____ Number of hours usually slept: _____

Where does your child sleep? _____

How is your child usually disciplined? _____

What is your child's diet like? _____

Our household is usually (check all that apply)

___ Quiet ___ Calm ___ Highly structured ___ Lots of conflict
___ Noisy ___ Active/Busy ___ More relaxed/unstructured ___ Tense

What activities does your child enjoy?

___ Video games ___ Telephone ___ Sports
___ TV/Movies ___ Reading ___ Shopping
___ Internet/computer ___ Art/Crafts ___ Playing outside
___ Being with friends ___ Playing with toys ___ Other _____

Hobbies: _____

Extracurricular activities: _____

Community activities/involvement: _____

Is there anything else you would like for us to know about your child's home life? _____

_____

Substance Use History

✓ if Used	Substance	Frequency of Use (# of days per week, month, year, etc.)	Amount per Use (# of drinks/hits/pills, $ amount, etc.)	When was your last use of this substance?
	Alcohol *(Beer, Wine, Liquor)*			
	Marijuana *(Cannabis, "Weed," "Pot")*			
	Cocaine *(Including Crack)*			
	Other Stimulants *(Amphetamines, Methamphetamines, Adderral, Ritalin, etc.)*			
	Heroin			
	Other Opiates *(Oxycodone, Hydrocodone, Methadone, Morphine, Codeine, Buprenorphine, etc.)*			
	Depressants/Sedatives *(Benzos, xanax, barbiturates,*			
	Hallucinogens *(PCP, LSD, "Shrooms," Ecstacy, Ketamine, etc.)*			
	Inhalants *("Whippets," paint thinner, glue, volatile solvents, etc.)*			
	Nicotine/Tobacco			
	Other:			

Have you ever had treatment or "classes" for drug or alcohol abuse or as a result of a DUI or drug related offense? Yes No

If Yes, Please complete the following:

Where? (Name of Facility/Location)	When? (Year/Month/Dates of Attendance)	Did you complete successfully

		?
1.		
2.		
3.		
4.		
5.		

SUBSTANCE USE/ADDICTION <u>PRESENT</u> **Yes** **No** **N/A**

1. Would you or someone you know say you are having a problem with alcohol?..... 1. □ □ □
2. Would you or someone you know say you are having problems with pills or illegal drugs?.□ □ □
3. Would you or someone you know say you are having problems with other addictions, i.e. gambling, pornography or shopping?..... 3. □ □ □
4. Have you ever been to a self-help group?..... 4. □ □ □

SUBSTANCE USE/ADDICTION <u>PAST</u> **Yes** **No** **N/A**

1. Would you or someone you know say you had problems with alcohol?..... 1. □ □ □
2. Would you or someone you know say you had problems with pills or illegal drugs? 2. □ □ □
3. Would you or someone you know say you had problems with other addictions, i.e. gambling, pornography or shopping?..... 3. □ □ □
4. Is there a family history of addiction in your family?..... 4. □ □ □
5. If yes, please describe: _____

Child Assessment: Please check all of the following that currently apply to your child.
Please indicate past concerns with the letter "P".

____ Anxiety
____ Depressed mood
____ Panic attacks
____ Racing thoughts or speech
____ Obsessions/Compulsions
____ Excessive fears or phobias
____ Dissociative states
____ Touchy/irritable
____ Nightmares
____ Sleep problems
____ Bedwetting or incontinence
____ Tantrums or "meltdowns"
____ Difficult to parent
____ Conflicting parenting styles
____ Parental marital problems
____ Adopted or in foster care
____ Lots of physical complaints

____ Hurts others
____ Lying
____ Stealing
____ Destroying property
____ Defiance
____ Blames others for mistakes
____ Angry/resentful
____ Lack of conscience
____ Bizarre behavior
____ Clingy
____ Separation anxiety
____ Seems to overreact
____ Parent feels overwhelmed
____ Argues with adults
____ Doesn't seem to listen
____ Seems adultlike or older
____ Life has been unstable

____ Hyperactive
____ Attention problems
____ Worries all the time
____ Impulsive
____ Low self-esteem
____ Suicidal thoughts
____ Suicide attempts
____ Self-mutilation
____ Sexually active / acting out
____ Difficulty with change
____ Needs predictability/routine
____ Unexplainable mood shifts
____ Running away
____ Deliberately annoys people
____ Takes excessive risks
____ Seems younger than age
____ Life changes pending

How did you hear about us? ___ Yellow Pages ___ Attorney: _____
___ Friend/Client ___ Doctor: _____
___ Internet ___ Other agency: _____
___ Court-ordered ___ Other: _____

To Be Completed By Therapist

Client strengths:

Client needs:

Client risks:

Client preferences:

Dx:

Based on the assessment, the recommended treatment is:

□ None	□ Housing Referral	□ Community Resources
□ Educational Services	□ Financial	□ Legal
□ Medical/Physical	□ Substance Abuse Treatment	□ Twelve-step Program
□ Psychiatric Assessment	□ Psychological Testing	□ Social Services
□ Inpatient MH Treatment	□ Outpatient MH Treatment	□ Parenting
□ Other: _____		

I certify that the information provided above is correct to the best of my knowledge, and that I am authorized to provide such information on behalf of this client.

Signature of Legally Responsible Person	Date
Signature of Therapist Completing Assessment	Date