PREASSESSMENT FOR CHILDREN & ADOLESCENTS

Name: _____ DOB: _____ Date: _____

What concerns you most about your child?

_____

_____

Briefly describe the events that led to this appointment:

_____

_____

What are your goals for the evaluation/treatment?

_____

_____

Have you seen other professionals about these problems? If so, list names and approximate dates (include hospitalizations).

_____

_____

Symptoms

Check if applicable	Current	Ever	Check if applicable	Current	Ever
Careless/poor attention to detail	_____	_____	Fidgets	_____	_____
Difficulty sustaining attention	_____	_____	Difficulty remaining seated	_____	_____
Doesn't listen	_____	_____	Runs about/subjectively restless	_____	_____
Doesn't follow through with requests	_____	_____	Difficulty playing quietly	_____	_____
Disorganized	_____	_____	"On the go"/ like "motor driven"	_____	_____
Avoid/delays effortful tasks	_____	_____	Excessive talk/blurts out	_____	_____
Loses necessary things	_____	_____	Difficulty waiting for turn	_____	_____
Easily distracted	_____	_____	Interrupts/intrudes	_____	_____
Forgetful in daily activities	_____	_____	Tobacco, alcohol, drug usage	_____	_____

Where are these problems present? Home _____ School _____ Other _____ Comments _____

_____

_____

(Continued on back side)

Symptoms

Check if applicable	Current	Ever	Check if applicable	Current	Ever
Expresses depressed mood	_____	_____	Lack of interest in friends/normal activity	_____	_____
Isolating from friends/family	_____	_____	Decreased concentration	_____	_____
Poor or excessive sleep	_____	_____	Decreased or increased appetite	_____	_____
Excess fatigue/tiredness	_____	_____	Hopeless/don't care	_____	_____
Suicidal talk or behavior	_____	_____	Access to firearms	_____	_____
Self-harm/cutting/burns	_____	_____			
Mood swings/mood changes without reason	_____	_____	Irritable/giddy/elated inappropriately	_____	_____
Loss of inhibition (risky behavior, hypersexual)	_____	_____	Overly concerned about weight/diet	_____	_____
Food binging or self-induced vomiting	_____	_____	Food restricting, excess exercise or laxatives	_____	_____

Comments _____

Check if applicable	Current	Ever	Check if applicable	Current	Ever
Excessive or unusual worries or fears	_____	_____	Perfectionistic	_____	_____
Sudden feelings of panic	_____	_____	Fear of speaking in public	_____	_____
Nail biting, thumb sucking, teeth grinding, hair pulling, skin picking.....				_____	_____
Overly concerned about germs, illnesses, or other health or safety concerns				_____	_____
Unusual repetitive behaviors or routines	_____	_____	Anxiety at bedtime or in the night	_____	_____
Require a lot of reassurances	_____	_____	Physically tense/unable to relax	_____	_____
Traumatic accident	_____	_____	Verbal/emotional abuse	_____	_____
Physical abuse	_____	_____	Sexual abuse	_____	_____

Comments _____

Check if applicable	Current	Ever	Check if applicable	Current	Ever
Odd thinking or peculiar ideas	_____	_____	Overly suspicious/untrusting	_____	_____
Hearing voices/seeing things not there	_____	_____	Distress over change in routine	_____	_____
Unusual toy or play interests (i.e. collections, line up or take apart toys rather than play)				_____	_____
Difficulty discerning what is real vs. normal fantasy play				_____	_____
Restricted conversational interests (i.e. dinosaurs or specific topics to the exclusion or other topics)				_____	_____

School History

What is your child's grade and school?

_____

What other schools has he/she attended? _____

Has your child received special education services? (i.e OT, speech therapy, PT, resource room, IEP, 504 plan)

_____

Has your child ever repeated a grade? _____ Has he/she ever been suspended or expelled? _____

Has your child been in trouble for too many tardy days? _____ refusing to attend? _____or missed days? _____

Comments _____

Performance:

Rate each good, fair, poor	Academic	Social Adjustment	Attitude
Preschool/Kindergarten	_____	_____	_____
Elementary School	_____	_____	_____
Middle School	_____	_____	_____
High School	_____	_____	_____

Medical History

Primary Care Provider _____ Drug/Food Allergies _____

Has your child seen a specialist? List names, approximate dates, and reason for consultation.

_____

Is your child current on immunizations? _____ Are there any current health concerns or frequent complaints by your child?

_____

Has your child had any of the following?

_____ Asthma/breathing problems	_____ Headaches	_____ Stomach/Bowel problems	_____ Seizures
_____ Concussion/blows to head/knocked out	_____ Ear Infections/Tubes	_____ Heart Problems	_____ Accidents
_____ Broken Bones	_____ Hearing Problems	_____ Sight/eye problems	_____ Other

If checked, please describe. _____

Has your child had any hospitalizations or surgeries? If so, identify reason and approximate dates.

_____

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Developmental History

Prenatal

Were there any complications with the pregnancy or your child's delivery (i.e. mother's health issues, exposure to substances, eclampsia, premature, breech, fetal distress, C-section)?

_____

_____

Infancy/Toddler

Were there any medical problems in the first two years of life? _____

Were there any feeding concerns? If so, explain. (i.e. colic, food or formula intolerance or allergy, picky eater)

_____

Were there any bowel or bladder concerns? If so, explain. (i.e. bed wetting, incontinence)

_____

Were there any concerns about temperament? (i.e. shy, aggressive, overly sensitive, not affectionate, fussy)

_____

Have there been issues with hypersensitivity to noise, tastes, textures, movement, being held, or other sensory experiences?

_____

Have there been any concerns with physical growth/development? (i.e. lack of growth, excessive clumsiness, fine motor skills)

_____

Have there been any sleep problems? (i.e. difficulty getting to or maintaining sleep, nightmares/terrors, bedwetting)

_____

At what age was your child meeting the following developmental milestones? Was he/she early, late, or average?

Crawling/walking _____

Bowel/bladder training _____

Talking _____

Was your child ever separated from either parent for a significant length of time?

_____

What questions or concerns, if any, do you or your child have about his/her sexual activity, identity or orientation?

_____

Family History

Please identify any known or suspected history of the following problems in the child's blood relatives. Indicate the relative and whether maternal or paternal (i.e. maternal aunt, paternal grandmother)

Anxiety, panic, worry _____ ADHD/attention problems _____

Depression or Suicide _____ Mood disorder/bipolar/manic depression _____

Schizophrenia _____ Eating problems/disorders _____

Alcohol problems _____ Drug problems _____

Learning Problem/developmental/intellectual problems _____

Behavior Problems _____ Court involvement _____

Diabetes _____ Heart problems _____

Thyroid Condition _____ Seizures/migraines _____

Social History

List the names, ages, and occupations/grades of family members, others living in the house hold, or other caretakers

Name	Age	Relationship	Job (if employed)	Living with child
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No

Are there any particular stressors or recent changes in the family such as job changes, legal problems, financial problems, school changes, health problems, marriage, separation or divorce, violence or substance abuse?

_____

_____

Who is responsible for discipline? What methods work or haven't worked? Do caregivers/parents agree on discipline?

_____

_____

What are family activities or mealtimes like? _____

What interests, activities or hobbies does your child enjoy? _____

How does your child get along with parents? _____ siblings? _____ peers? _____ self? _____