



Child and adolescent mental health assessment (10 pages)

Name: _____ Address: _____

Gender: _____ date of birth: _____ age: _____

Race: _____ languages spoken: _____

Phone Number: _____ work number: _____

Parents' or guardians' name: _____

School name: _____ grade: _____

Contact person at school: _____ phone: _____

Chief concern:

Please describe your child's main difficulty that has brought you to see me? _____

Who referred you to us and what was the main reason for the referral: _____

Please describe how and when did these problems begin? Include duration, severity, onset, frequency, and context: _____



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YASMEEN KHAN (630) 674 1138
FAX: 630-690-3353

How would you describe your/your child's sleep pattern: _____

How would you describe your/your child's eating habits: _____

What is your/your child's weight: _____

Describe bowel and bladder habits: _____

How do you/your child function most of the time-in school, home, public places and with friends: _____

In your opinion, what are some of the stressors or difficulties that you/your child has? _____

How has this problem effected you/your child and your family: _____



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How do you/your child try to cope with these problems: _____

Describe yourself/your child before these problems began: _____

What do you like about yourself/your child's positive behaviors at home, school, and social situations: _____

In your opinion, what are some of your/your child's weaknesses: _____

Have you/your child received treatment for this problem before? If yes, please describe where, when, by whom, results, duration, any medications, hospitalizations etc: _____



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Please describe what worked and what did not work in past treatment: _____

Medical history:

Physical health status, any major illnesses, surgeries, physical impairments or concerns you are worried about: _____

List any medications taking at present: _____

Personal development history

How was pregnancy and delivery when you were born? Any complications. How was prenatal health. _____

How were developmental milestones? When did you/your child learn to sit, stand, walk, and toilet trained. _____



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How was language development? When did you/your child learn to talk? Any problems with hearing, or speech: _____

How were the first few months of life: infant's sleeping behaviors, temperament, breast feeding etc. _____

How have you/ your child been doing at school. How are your/your child's current grade, adjustment at school, aptitudes and interests, academic goals: _____

Do you/your child receive special education services: _____

How do you/your child spend your free time: _____

Does religion or spirituality play a role in your family? f yes, please explain: _____



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Have you talked to your child about sex education? How did your child react: _____

List 5 things that you wish for yourself/your child to change: _____

Family background:

Please list members of your family.

Name relation age occupation education lives where

Any extended or step family? Their names, ages, relationship etc:

Have you/your child been physically or sexually abused? If yes, please describe: _____



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Has any member of your family been physically or sexually abused? If yes, please describe: _____

Tell me more about your family's customs, traditions, and beliefs: _____

The child's parents' relationships with each other: _____

Child's relationship with each parent and with other adults present; past and present: _____

Child's relationship with siblings; past and present: _____

How is your family's physical health: _____



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Do you smoke, drink, or use drugs. Does anyone in your family drinks or do drugs: _____

Have there been any emotional problems in the family? If yes please describe: _____

Have there been any major changes in the family? (For example, death, divorce, remarriage, separation): _____

What kind of discipline is used at home: _____

Do you/your child have friends? How do you/your child get along with same sex and opposite sex friends and adults? _____

Is there anything else that is important for you to tell me as your therapist? _____



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For service provider only:

Mental status: _____

Diagnosis: _____

Client's level of motivation: _____

Summary of evaluation: _____

Signature: _____ *Date:* _____

- Parent goal checklist (1 page)
- Child problem checklist (1 page)
- Charting child behaviors (1 page)
