WINNING AT HOME

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Child Assessment Form

CONFIDENTIAL

Child's Name: _____ **Age:** _____ **Date Of Birth:** / /

School: _____ **Grade:** _____ **Grades Retained:** _____

Form Completed By: _____ **Relationship:** _____

Child Currently Lives With: _____

FAMILY MEMBERS

Relationship	Name	Age	Sex	Occupation/ School Grade	Living in the Home?
Parent 1					
Stepparent					
Parent 2					
Stepparent					
Sibling					
Sibling					
Sibling					
Sibling					

OTHER ADULTS CURRENTLY LIVING IN THE HOME:

Name	Age	Relationship

Form continues on back side

HISTORY

If parents are separated or divorced, please describe visitation or co-parenting schedule:

Describe any significant conflicts between the parents:

Reasons child is being referred for counseling:

Any previous counseling (dates/therapist name):

DEVELOPMENTAL HISTORY

Mother's Pregnancy

Illness or complications?	YES	NO	C-Section?	YES	NO
Smoking during pregnancy?	YES	NO	Premature Delivery?	YES	NO
Using drugs/alcohol during pregnancy?	YES	NO	If yes, gestational age at delivery:		
Take medications during pregnancy?	YES	NO	Length of hospitalization after delivery:		

Were any of the following present during child's early childhood? Please check the appropriate boxes:

○ Did not enjoy cuddling	○ Demanding/Clingy	○ Difficulty Sleeping	○ Developmental delays
○ Irritability	○ Difficult to comfort	○ Ear infections	○ Excessive Sleep
○ Head Banging	○ Seizures	○ Eating Difficulties	○ Colic

Was the child adopted? YES NO **If yes, at what age?** **From what country?**

Please list what is known about care received before adoption:

Major history of learning or behavioral problems at home or school? YES NO

If yes, please explain:

MEDICAL HISTORY

Any childhood illnesses? YES NO **If yes, please list:**

Hospitalizations/operations? YES NO **If yes, please list:**

Head injuries? YES NO **If yes, please list:**

Eye problems? YES NO **If yes, please list:**

Allergies? YES NO **If yes, please list:**

PRESENT MEDICAL

Conditions/Concerns:

Current medications & reasons for each:

Doctor prescribing: **Phone Number:**

CURRENT CONCERNS

Please check any of the following that are concerns for your child:

- ○ Reading
- ○ Handwriting
- ○ Does not Listen
- ○ School Phobia
- ○ Destroys Property
- ○ Bedwetting
- ○ Forgets Easily
- ○ Soils Pants
- ○ Comprehension
- ○ Poor Hygiene
- ○ Distractibility
- ○ Math
- ○ Easily Frustrated
- ○ Drug/Alcohol Use
- ○ Tantrums
- ○ Disorganized
- ○ Poor Peer Relations
- ○ Talks Excessively
- ○ Aggressive
- ○ Frequent Accidents
- ○ Mood Changes
- ○ Poor Response to Discipline

Type of discipline you use:

Child's response to discipline:

Child's interests/talents:

Recent losses/changes in home:

Family history of drugs/alcohol/mental illness (describe):

Any other information you feel would be helpful:

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PARENT OBSERVATIONS & SYMPTOM CHECKLIST

Child's Name: _____ **Age:** _____

Parent's Name: _____ **Date:** / /

Behavior	None	Mild	Moderate	Severe
Poor impulse control				
Aggression toward others (physical/verbal)				
Inappropriately demanding & clingy				
Deceitful (lying, conning) behavior				
Sleep disturbances				
Hyperactivity				
Persistent nonsense questions, incessant chatter				
Difficulty with novelty and change				
Perceives self as victim (helpless)				
Intense displays of anger (rages that can't be soothed)				
Frequently sad, depressed, hopeless				
Extreme mood changes				
Lack of eye contact				
Cannot tolerate limits and external control				
Lacks trust in others				
Manipulative, controlling, bossy				
Lack of remorse or conscience				
Does not like to be touched				
Accident prone				
Poor hygiene				
Victimizes others (bully), seeks revenge				
Blames others for own mistakes or problems				
No stable peer relationships				
Indiscriminately affectionate with strangers				
Poor self-esteem				
Does not seem to listen when spoken to directly				
Victimized by others				
Learning disorders/problems in school				
Lack of cause and effect thinking				
Cruelty to animals				
Inappropriate sexual conduct and attitudes				
Pre-occupation or obsessions with an object				
Frequently defies rules (oppositional)				
Abnormal eating habits				
Destruction of property				
Consistently irresponsible				
Stealing				
Unusually fearful				
Grandiose sense of self-importance/entitlement				
Poor organization and planning skills				