Associates of Behavioral Health Northwest
CHILD/ADOLESCENT PSYCHOSOCIAL ASSESSMENT

Name: Date:

I. PRESENTING PROBLEM

What events or stressors led you to seek therapy at this time? Check all that apply.

- ❑ Mood difficulties (i.e. sad or depressed mood, mood swings)
- ❑ Distressing Thoughts or Feelings
- ❑ Difficulty Functioning in Everyday Life
- ❑ Anxiety (i.e. panic attacks, chronic worry, obsessive thoughts, flashbacks/distressing dreams)
- ❑ Difficulty adjusting to major life changes
- ❑ Relationship stressors
- ❑ Self-esteem issues
- ❑ Substance Abuse: Please Specify substance(s):
- ❑ Behavioral Addictions (such as gambling, spending, sex, pornography, exercise, etc)
- ❑ Other:

Please give a brief description of the areas you checked above:

II. SYMPTOM CHECKLIST

Please indicate whether you are currently experiencing the following symptoms (within the past two weeks) or if you have in the past. If you have NOT experienced the symptoms, you do not need to mark anything.

Depressed/Sad Mood	Current	Past	Excessive Fear of Social Situations	Current	Past
Daily Irritability	Current	Past	Panic Attacks	Current	Past
Loss of Interest in Pleasurable Activities	Current	Past	Chronic Worry	Current	Past
Changes in Appetite (increase or decrease)	Current	Past	Reoccurring Distressing Dreams	Current	Past
Changes in Sleep (increase or decrease)	Current	Past	Feeling Detached from Reality	Current	Past
Difficulty Concentrating	Current	Past	Flashbacks of Past Distressing Events	Current	Past
Fatigue, or Loss of Energy	Current	Past	Physical Abuse	Current	Past
Feelings of Worthlessness or Excessive Guilt	Current	Past	Psychological/Mental Abuse	Current	Past
Rapid Mood Swings	Current	Past	Sexual Abuse	Current	Past
Recurrent Thoughts of Death	Current	Past	Traumatic Event(s)	Current	Past
Racing Thoughts	Current	Past	Difficulty Controlling Anger	Current	Past
Feeling more Self-Confident than Usual	Current	Past	Self-Injury Behavior	Current	Past
Having Much More Energy than Usual	Current	Past	Assaulted Someone Else	Current	Past
More Talkative than Usual	Current	Past	Disturbed Eating Patterns	Current	Past

Easily Distracted	Current	Past	Binging and Purging	Current	Past
Spending Money Carelessly	Current	Past	Using laxatives	Current	Past
Taking More Risks than Usual	Current	Past	Restricting Intake	Current	Past
More Interested in Sex than Usual	Current	Past	Overeating	Current	Past
Paranoia	Current	Past	Excessive Dieting	Current	Past
Hallucinations	Current	Past	Excessive Exercising	Current	Past
Delusions	Current	Past	Preoccupation with Weight/Dieting	Current	Past
Fear of Going Crazy	Current	Past	Other:		

Comments:

III. SUICIDAL/HOMICIDAL IDEATION

1. Have you ever attempted to kill yourself (suicide) or another person (homicide)? ***(Circle) Yes No***

   If yes, how and when?

2. Are you currently having thoughts of harming yourself or others? ***(Circle) Yes No***

   If yes, describe your thoughts/plan.

IV. PSYCHIATRIC TREATEMENT HISTORY

Please list any psychiatric care that you have received, including hospitalizations (inpatient or outpatient), therapists or psychiatrists.

Date(s)	**Facility and Provider** (Dr./Hospital/Therapist)	**Frequency of Visits**	**Duration** (# of sessions/ years)	**Reason**

1. Are there any providers you would like involved in your care?

V. PHYSICAL HEALTH

1. Are you currently taking any medications (prescribed or over the counter)? If yes please indicate the following:

Medication **Dosage/Frequency** **Prescribing MD** **Purpose**

Medication	Dosage/Frequency	Prescribing MD	Purpose

*If there isn't enough space here for you to write in all of your medications, please continue on the back of this page.

2. Do you have any current physical health problems? If so, please specify.

   a. Are you being treated for these medical problems?

   b. If so, by whom?

VI. SUBSTANCE USE HISTORY

Please indicate how often you have used the following substances in the **past 1-3 months** by placing an X in the corresponding boxes. If you have never used the substance or used a substance, but not in the past 1-3 months, mark the appropriate column.	**1-2 x**	**1x/ Month**	**Weekly**	**Daily/ Near Daily**	**Past, But NOT in Last 3 Months**	**Never**
Alcohol						
Tobacco Products						
Cannabis						
Cocaine/Crack Cocaine						
Heroin						
Prescription Pain Medications						
Benzodiazepines/Sedatives (Xanax, Ativan, Klonopin, etc)						
Sleep Aides (Ambien, Lunesta, etc.)						
Prescription Stimulants						
Methamphetamine						
Hallucinogens (LSD, Mushrooms, Acid, DXM)						
Ecstasy						
Inhalants						
Other: (Specify)						

For substances you have used in the past 3 months, please indicate the date of last use, amount used and typical pattern of use.

Substance	Date of Last Use	Amount Used	Typical Pattern of Use

1. Have you noticed a recent increase in your use of substances?_

2. Do you think that your substance use is a problem?
3. Has anyone ever told you they think you have a substance abuse problem?
4. Have you ever had problems with addictive behaviors such as gambling, internet, sex, pornography, shoplifting, exercise, work, videogames, etc? If yes please describe.

VII. FAMILY HISTORY

1. Does anyone in your family have a history of substance use/abuse addictive behaviors or mental health problems?
2. Has anyone in your family attempted or completed suicide?

VIII. DEVELOPMENTAL HISTORY (child and adolescent)

1. Any problems or complications with Mother's pregnancy, delivery or immediately after birth?

_____

2. Any delays in your child's ability to sit up, crawl, walk without help, speak first words, say basic phrases, stay dry all night, (please circle and explain) _____
3. Has your child refused school for more than three days in a row?_____
4. Does your child/teen have a health peer group?_____
5. Does your child/teen follow the rules, obey the law, respect authority figures?_____
6. Do you have any learning difficulties?
7. Are you active in any sort of religious denomination or faith?
8. Are there any cultural or spiritual factors that you feel may affect your treatment?

IX. SEXUALITY

1. Do/did you have any current or past problems related to your sexuality or sexual orientations?

   Yes ***No*** If yes, please explain. _____

2. Have you been sexually active in the past? ***Yes*** ***No***

3. Are you currently sexually active? ***Yes*** ***No***

4. If yes, do you use any type of protection? ***Yes*** ***No***

X. SOCIAL ENVIRONMENT

1. Who do you live with?
2. Who do you spend most of your free time with?
3. Who would you describe as your support system (i.e. family, significant other, close friend, community support, etc.)?
4. What do you enjoy doing in your free time?

XI. WORK/SCHOOL

1. Employment/School Status (See Registration Form)
2. What is the nature of your job (i.e. responsibilities, tasks, etc)?

3. Are you experiencing any difficulties at work/school? ***Yes*** ***No***

If yes, please describe.

XII. LEGAL PROBLEMS

Please indicate any legal problems you may have experienced in the past or are currently experiencing. Check all that apply.

❑ Charges as a Minor	❑ Arrests	❑ Incarcerations	❑ Convictions
❑ Probation	❑ Parole	❑ Bankruptcy	❑ Civil Suits
❑ Child Custody Issues	❑ DUI(s)	Other: _____	

Please briefly discuss any of the items marked above.

XIII. STRENGTHS/LIMIATIONS

1. Describe your strengths (things that you are good at, things you like about yourself, etc.)

2. Describe any limitations you may have.
3. If your best friend were to describe you in three words, how would he/she describe you?

4. What is going well in your life right now?

4. What would you like to accomplish in therapy?