Solution Focused Therapy Services, LLC

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CHILD/ADOLESCENT & FAMILY PSYCHOSOCIAL FORM-Revised

Identifying Information of Child

Name of Child/Adolescent : _____ Sex: ____ DOB: _____ Age: _____

Education

Name of School: _____ Grade: _____

Name of Mother: _____ Sex: ____ DOB: _____ Age: _____

Name of Father: _____ Sex: ____ DOB: _____ Age: _____

Other Caregivers: _____ Sex: ____ DOB: _____ Age: _____

Chief Complaints

Child's Presenting Problems: (check all that apply)

- ___ Very unhappy
- ___ Irritable
- ___ Temper outbursts
- ___ Withdrawn
- ___ Daydreaming
- ___ Fearful
- ___ Clumsy
- ___ Overactive
- ___ Slow
- ___ Short attention span
- ___ Distractible
- ___ Lacks initiative
- ___ Undependable
- ___ Peer/Partner Conflict
- ___ Disobedient
- ___ Stealing
- ___ Bedwetting
- ___ Phobic (specify) _____
- ___ Impulsive
- ___ Stubborn
- ___ Frequent Lying
- ___ Sexual Difficulties
- ___ Mean to others
- ___ Destructive
- ___ Trouble with the law
- ___ Eating problems
- ___ Self-mutilating
- ___ Sleeping problems
- ___ Sickly
- ___ Shy
- ___ Tics
- ___ Procrastination
- ___ Infantile
- ___ Truancy
- ___ Soiled Pants
- ___ Uncontrollable Worry (specify) _____
- ___ Nightmares
- ___ Flashbacks
- ___ Difficulty leaving the house
- ___ Panic
- ___ Communication Difficulties
- ___ Work Stress
- ___ Frequent tearfulness
- ___ Homicidal thoughts/Thoughts of harming others
- ___ Strange behavior (specify) _____
- ___ Strange thoughts (specify) _____
- ___ Drug abuse/dependence
- ___ Alcohol abuse/dependence
- ___ Suicidal Thoughts
- ___ Fire Setting
- ___ School Performance
- ___ Head Banging/Rocking

Other (Explain): _____

How long have these problems occurred? (number of weeks, months, years):_____

_____

What makes you seek help at this time?_____

_____

Precipitating Events: Were there any precipitating events (e.g. major family illness or death, divorce, moving to a new residence, etc.)?

_____

_____

_____

Child Health/Mental Health Information

1.Is the child currently receiving psychiatric services or counseling elsewhere? **Yes___ No___**

_____

_____

2. Has the child had previous psychological counseling? **Yes___No___**
If yes, to the best of your ability please note your age and duration of previous counseling experience(s):

_____

_____

3. Have the child ever been hospitalized for psychiatric reasons? **Yes___No___**
If yes, what hospital, approximate dates, precipitating event:

_____

_____

_____

4. Is the child currently taking prescribed psychiatric medication (antidepressants or others)? **Yes___No___**
If yes, please list medication, dosage, and the approximate date treatment began:

_____

_____

5. Has the child been prescribed such medications in the past? **Yes___No___**
If yes, please list medication, dosage, and the approximate date treatment began and ended:

_____

_____

6. Is the child currently taking any other prescribed, over the counter medication, or vitamins (e.g., for hypertension, migraines, asthma etc.)?
Yes___No___ - If yes, please list medication, dosage, and the approximate date treatment began:

_____

_____

13. Please list any current or ongoing physical symptoms, chronic illnesses, or other health concerns or conditions for the child (e.g. chronic pain, headaches/head trauma, asthma fibromyalgia, diabetes, etc.):

_____

_____

Academic Performance

Highest grade on last report card? _____

Lowest grade on last report card? _____

Favorite Subjects: _____

Least Favorite Subjects: _____

Does child/adolescent participate in extracurricular activities: **Yes___No___**

Indicate activities:_____

What are child's/adolescent's educational aspirations: _____

List child/adolescent's special interest, hobbies, skills: _____

_____

Additional Comments

Please indicate other concerns of child/adolescents: _____

_____

_____

SOCIAL HISTORY AND OTHER ISSUES

1. Describe the child/adolescent's relationship status _____
2. Child's gender identity & preferred pronouns: _____
3. Child's Sexual orientation: _____
4. Describe the child's living situation (with whom, type of housing, etc.) below:

_____

5. List any family members that are currently a source of support for the child:

_____

6. List any friends that are currently a source of support for the child:

_____

7. List any other sources of support (i.e. Church, activities, etc.):

_____

8. Has the child ever experienced or witnessed domestic violence or abuse? **Yes___No___**
9. Have the child ever experienced sexual abuse, assault, or uncomfortable touching? **Yes___No___**
10. Has the child experienced suicidal thoughts recently? **Yes___No___** How Recently?_____
(If yes, circle applicable response): **Frequently___Sometimes___Rarely___Never___**
11. Has the child had suicidal thoughts in the past? **Yes___No___**
(If yes, circle applicable response) **Frequently___Sometimes___Rarely___Never___**
12. Has the child ever attempted suicide? **Yes___No___**
(If yes, please list the age(s) of the attempt(s)) :_____
13. Has the child ever intentionally inflicted any other form of harm upon him or herself? **Yes___No___**
14. Has the child intentionally inflicted any form of harm upon anyone else recently? **Yes___No___**
15. Does the child currently have any legal concerns or issues pending? **Yes___No___**
(If yes, please specify)_____

HEALTH RELATED ISSUES

1. How many times per week does the child exercise? _____ For about how long each time_____
2. Does the child regularly use alcohol? **Yes___No___**
How often does the child use alcohol? _____
What does he/she typically drink? _____
Has the child ever felt the need to cut down on the amount of alcohol he or she drinks? **Yes___No___**
3. How often does the child engage in recreational drug use?
Daily___Weekly___Monthly___Rarely___Never___
List any recreational drugs the child currently uses and how often he or she uses them:

_____

4. Does the child/adolescent have any problems or worries about sexual functioning? **Yes__No__**
(If yes, circle applicable response): **Lack of desire___ Performance Problem___ Sexual Impulsiveness___ Difficulties Maintaining Arousal___ Worried about STDs (Sexually Transmitted Diseases)___Other___**

CURRENT FAMILY RELATIONSHIPS

Mother-Relationship to child/adolescent: ☐ Natural ☐ Step ☐ Relative ☐ Adoptive

Occupation _____ Education: _____ Age: ____

Father-Relationship to child/adolescent: ☐ Natural ☐ Step ☐ Relative ☐ Adoptive

Occupation _____ Education: _____ Age: ____

Marital History of parents: __ married/when?____ __sep/when?____ __div/when?___

Deceased: __mother/when?___ __father/when? ___Step-parents: ☐ married/when?____

If child/adolescent is adopted, when did this occur and *has the child been told*? _____

Brothers and Sisters: (indicate if step-brothers or step-sisters):

Name	Age	Sex	Living at Home (y/n)	Type of Relationship

Parents Marital/Co-habitating Relationship

If parents are married or co-habitating, please give a brief description of the relationship:

_____

_____

_____

_____

_____

Any history of abuse (emotional, physical, sexual, domestic violence) in parents' previous or current intimate relationship?

_____

_____

Parent Mental Health/Health History

Do you (parent) or anyone in your family have any current or past mental health or health concerns? List current and previous mental health/health treatments and/or hospitalizations. (Include dates, interventions, treatment outcomes, and medications)

_____

_____

_____

_____

Parent Drug and Alcohol Use

Any family history of drug and/or alcohol usage: List and describe:

_____

_____

Family Expectations

What are your expectations of your child/adolescent?:_____

_____

What changes would you like to see in yourself and your family? _____

_____