

**PREASSESSMENT FOR CHILDREN & ADOLESCENTS**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

What concerns you most about your child?

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Briefly describe the events that led to this appointment:

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What are your goals for the evaluation/treatment?

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

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**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 _____	

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## 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 bingeing 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 of 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:

<u>Rate each good, fair, poor</u>	<u>Academic</u>	<u>Social Adjustment</u>	<u>Attitude</u>
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)?

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### 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)

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

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

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

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

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

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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?

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

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**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

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?

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

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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? \_\_\_\_\_