PREASSESSMENT FOR CHILDREN & ADOLESCENTS

Name: _____ DOB: _____ Date: _____

What concerns you most about your child?

_____

_____

Briefly describe the events that led to this appointment:

_____

_____

What are your goals for the evaluation/treatment?

_____

_____

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

_____

_____

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 _____

_____

_____

(Continued on back side)

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 binging 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 or 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:

Rate each good, fair, poor	Academic	Social Adjustment	Attitude
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)?

_____

_____

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)

_____

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

_____

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

_____

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

_____

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

_____

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

_____

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?

_____

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

_____

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 ☐
				☐ Yes/No ☐
				☐ Yes/No ☐
				☐ Yes/No ☐
				☐ Yes/No ☐
				☐ Yes/No ☐
				☐ 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?

_____

_____

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

_____

_____

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? _____