CLINICAL ASSESMENT TOOL – CHILD & ADOLESCENT

Name: _____ **Date**: **_____**
Date of Birth**:** _____ Age/ Grade**: _____**
School**:** _____ Classroom: Regular_____ Other_____

Please list the members of the child's current household:

Full Name	Relationship to Child	Age

Other relatives not living with the child:

Full Name	Relationship to Child	Age

Is there a family history of the following?	**Mother's side or Father's side**		
1. Seizure disorder	M or F	10. Early arithmetic problems	M or F
2. Early reading or spelling problems	M or F	11. Significant shyness	M or F
3. Significant medical illness	M or F	12.Anxieties; fears; phobias	M or F
4. Early speech or language problems	M or F	13. Problems paying attention/concentrating	M or F
5. Motor incoordination	M or F	14. Restlessness, fidgetiness	M or F
6. Drug or alcohol abuse	M or F	15. Motor or vocal tics	M or F
7. Depression or mania	M or F	16. Hyperactivity	M or F
8. Mental retardation	M or F	17. Psychosis; schizophrenia	M or F
9. Mental hospitalization	M or F	18. Sexual abuse	M or F

What are the primary concerns you have for your child at this time? _____
_____

PRENATAL HISTORY

1. **Mother smoked cigarettes**? Yes No If yes, how many a day on average? _____
2. **Mother drank**? Wine Beer Mixed Drinks How many days a week on average? _____
   How many drinks at a time on average? _____
3. **Mother used "street drugs"**? Yes No If yes, which ones? _____
   _____
4. **Mother had bleeding**? Yes No If yes, when during pregnancy? _____
5. **Mother was on prescribed medications during pregnancy**? Yes No If yes, which ones?
   _____
   Why? _____
6. **Check any medical conditions mother had during pregnancy**:
   ___loss of consciousness ___high blood pressure ___low blood pressure
   ___diabetes ___toxemia ___Nutritional deficiency
   ___emotional problems ___other (specify) _____

NEONATAL (Birth) HISTORY

1. **Age of mother at child's birth**? _____ Was pregnancy full term? Yes No
2. **Labor was**? Easy Average Difficult
3. **Birth was**? Head first Breech Cesarean Were forceps used? Yes No
4. **Birth weight was**? _____pounds, _____ounces
5. **Did baby have breathing problems at birth**? Yes No
6. **Was baby in any kind of stress at birth**? Yes No Explain:_____
7. **Check any medical conditions baby had at birth**: ___brain tumor(s) ___respiratory problems
8. ___hydrocephalus ___hyper/hypothyroidism ___brain infections ___hyper/hypoglycemia
   ___blood disorders ___high or low calcium ___convulsions ___high or low sodium
   ___Spinal Bifida ___Turner's syndrome ___jaundice mild or severe
   ___Other _____

EARLY CHILDHOOD HISTORY (0-3 YEARS)

1. **Was baby colicky**? Yes No When did colic go away? _____Months
2. **Approximate age baby sat up alone**? _____ Walked? _____
3. **Approximate age baby said first words**? _____ First phrase? _____
4. **Did baby have allergies**? Yes No To what? _____
5. **Did baby have any problems falling to sleep**? Yes No
6. **Did baby have any serious problems eating**? Yes No If yes, what problems? _____
   _____
7. **Baby was**? underactive overactive easy difficult happy anxious cranky calm
8. **Did baby have frequent ear infections**? Yes No Fevers over 104 degrees? Yes No
9. **From birth through age three, was baby hospitalized**? Yes No
   At what age For what reason Outcome
   _____
   _____
   _____
10. **Did baby experience loss of consciousness**? Yes No Seizures? Yes No
    Meningitis or encephalitis? Yes No Do to hay fever? Yes No
11. **From ages 18 months to 3 years, did the child have**?
    ___speech disturbances ___clumsiness ___odd behaviors that worried you ___a lot of energy
    ___hearing problems ___vision problems ___specific, out of the ordinary traumas
    ___aggressive behaviors beyond the ordinary ___difficulty understanding spoken words
12. **If your child attended daycare, what did daycare workers tell you about your child**? _____
    _____
13. **What age was your child successfully toilet trained**? ____ Was training? Easy Difficult
14. **Did your child lose control of his/her bladder repeatedly following toilet training?**
    During the day? Yes No During the night? Yes No
    Did your child lose control of his/her bowels following toilet training during the day? Yes No

PRESCHOOL HISTORY (3-5 YEARS)

1. **Did the child suffer any serious illness during these years**? Yes No If yes, what? _____
   _____
   If the child was hospitalized, please list: when, how long and outcome: _____
   _____
   _____
2. **Was the child**? ___inarticulate ___inattentive ___unhappy
   ___clumsy ___uncoordinated ___noncompliant ___too energetic/restless
   ___anxious ___hard to discipline ___overly aggressive ___unable to understand language
3. **Did the child attend**? ___Preschool Name of school: _____
   ___Kindergarten Name of school: _____
4. **Was there a significant separation anxiety at**? ___Preschool ___Kindergarten
5. **Were there problems with learning in Kindergarten**? Yes No
   If yes, were these problems? ___attention span ___speech disturbances ___listening
   ___sitting still ___learning to count ___saying ABC's
6. **Were there problems getting along with other children during preschool or kindergarten**? Yes No
   If yes, were these problems? ___over-aggressive ___unable to share ___shy ___withdrawn
7. **Was the child a problem for parents at home**? Yes No If yes, how?
   ___didn't listen ___clingy ___didn't obey ___trouble separating ___cried a lot
   ___worried excessively about something happening to parents ___other (specify) _____
   _____
8. **Did the child have significant problems getting along with brothers or sisters**? Yes No
   If yes, explain: _____
   _____
9. **Were there any significant marital problems**? Yes No How were the marital problems manifested in the home (e.g., yelling, physical violence) and how did the child react to the parents' problems? _____

10. **Were there significant medical problems from ages 3-5**? Yes No If yes, explain: _____
_____

11. **Did your child develop motor tics (sudden, brief, recurrent, meaningless movements) such as**:
___eye blinking ___mouth movements ___shoulder shrugs ___arm jerks ___finger movements
___head jerks ___facial gestures ___abdominal tensing ___imitation of someone else's movements
Did they last over one year? Yes No Which of these movements still exist? _____
_____

12. **Did your child develop vocal tics (simple, sudden, meaningless sounds or noises) such as**:
___throat clearing ___barking ___sniffing ___repeating his/her own sounds or words ___grunting
___repeating someone else's sounds or words ___repeating socially unacceptable or obscene words
Did they last for over one year? Yes No Which of these movements still exists? _____
_____

ELEMENTARY SCHOOL YEARS

1. **During elementary school, did your child have any of the following symptoms**?

A. Clumsiness Yes No
B. Attention span difficulties Yes No
C. Trouble telling left from right Yes No
D. Trouble with reading in the following areas
   1. Reading accuracy Yes No 3. Reading speed Yes No
   2. Reading comprehension Yes No 4. Trouble with phonics Yes No
E. Was your child entered into:
   1. Reading improvement Program (RIP) Which grade(s)? _____ Yes No
   2. Title I Reading Class Which grade(s)? _____ Yes No
   3. Resource Room (special education) placement Which grade(s)? _____ Yes No
F. Trouble spelling:
   1. Writing letters backward Yes No
   2. Needing a lot of help learning weekly spelling words Yes No
   3. Sloppy handwriting a possible reason for poor spelling Yes No
   4. When writing a composition on his/her own, would there be a lot of spelling errors? Yes No
   5. Good performance on weekly tests Yes No
   6. Learning his/her spelling words, but forgetting them a week or so later Yes No
G. Arithmetic:
   1. Does your child know his/her basic addition/subtraction facts Yes No
   2. If old enough, has your child had trouble learning how to borrow in subtraction Yes No
   3. If old enough, has your child had trouble learning multiplication tables Yes No
   4. Does your child's poor handwriting interfere with lining up columns of numbers correctly Yes No
   5. Does your child tend to make careless arithmetic errors when left alone to do homework Yes No
H. Does your child have:
   1. Trouble understanding the speech of others Yes No
   2. Trouble with speech articulation Yes No If yes, was the child in speech therapy? Yes No Where and when? _____
   3. Was your child ever held back? Which grade(s)? _____ Yes No

2. **When your child was young (5-12), did he/she**:

A. Make careless mistakes in schoolwork or other activities Yes No
B. Have trouble concentrating Yes No
C. Have problems listening Yes No
D. Have difficulty following instructions Yes No
E. Have difficulty organizing tasks and activities Yes No
F. Avoids, dislikes to engage in tasks that require sustained mental effort Yes No
G. Often loses things necessary for tasks and activities (e.g., school assignments, pencils, books, tools, etc.) Yes No

H. Become easily distracted Yes No
I. Is often forgetful in daily activities Yes No
J. Become fidgety, squirmy, restless Yes No
K. Have trouble remaining seated in class Yes No
L. Often run around or climb excessively in inappropriate situations Yes No
M. Have difficulty playing or occupying self quietly Yes No
N. Remain constantly "on the go" Yes No
O. Become excessively talkative Yes No
P. Have trouble waiting turn in groups Yes No
Q. Often interrupt or intrude on others Yes No
R. Often blurt out answers before questions were completed Yes No

3. **Did you, your spouse, a family member or your child's teacher(s) ever use the word "hyperactive" to describe your child**? Yes No

Who used the term? _____

Was your child ever placed on any medication for attention/hyperactive disturbance? Yes No

If yes, which medicine _____

At what age? _____ For how long? _____ Was it effective? Yes No Unsure

4. **During ages 5-12, did/does your child**:

A. Fear separation from home or parents Yes No
B. Fear harm would befall you or your spouse Yes No
C. Fear going to school Yes No
D. Have excessive fear of being alone Yes No
E. Feel reluctant to go to sleep at night Yes No
F. Worry that unwarranted events will lead to separation Yes No
G. Feel afraid to be away from home overnight Yes No
H. Have repeated nightmares with the theme of separation from parents Yes No
I. Complain of physical symptoms (e.g., headaches, stomachaches, etc.) when separating from parents Yes No

5. **In the past 12 months, has your child behaved in the following ways**:

A. Often threatened or intimidated by others Yes No
B. Often initiates physical fights Yes No
C. Used a weapon in a fight Yes No
D. Been physically cruel to animals or people Which or Both?_____ Yes No
E. Stolen while confronting victim Yes No
F. Forced someone into sexual activity Yes No
G. Set fires Yes No
H. Deliberately destroyed other's property Yes No
I. Broken into someone's house, building or car Yes No
J. Often lied to obtain goods, or "cons" others Yes No
K. Stolen valuable items without confronting victim (e.g., shoplifting, forgery) Yes No
L. Often stayed out at night despite parental prohibition Yes No
M. Run away from home overnight more than once Yes No
N. Often been truant from school, beginning before age 13 Yes No
O. Was there any behavior in section 5 that began prior to 10 years old Yes No
P. Any juvenile Court involvement Yes No If yes, what are the charges? _____

_____

Would you rate these behaviors as ___Mild ___Moderate ___Severe

6. **During the past six months, has your child**:

A. Repeatedly lost his/her temper Yes No
B. Often argued with adults Yes No
C. Been angry and resentful Yes No
D. Been spiteful and vindictive Yes No
E. Been easily annoyed by others Yes No
F. Often defied adult requests or rules Yes No
G. Deliberately annoyed other people Yes No
H. Often blamed others for his/her mistakes Yes No

7. **Over the past six months, has your child**:

A. Been restless or felt keyed up or on edge Yes No
B. Been easily fatigued Yes No

C. Had difficulty concentrating or mind going blank Yes No
D. Been irritable Yes No
E. Had muscle tension Yes No
F. Had a sleep disturbance (difficulty falling asleep, or restless and unsatisfying sleep) Yes No
G. Worried about the quality of their performance or competence at school or in sporting events Yes No
H. Worried a lot about how things in the future will turn out Yes No
I. Worried about whether things done in the past were acceptable to others Yes No
J. Become overly conforming, perfectionistic and unsure of him/herself and required excessive reassurance about his/her performance Yes No

8. **Over the past year, has your child**:

A. Had excessive fear of weight gain or weight loss Yes No Which or Both? _____
B. Refused to maintain a minimally normal weight for his/her age and height Yes No
C. Felt fat when he/she is not Yes No
D. Dieted excessively Yes No
E. Overly evaluated him/herself according to his/her body weight Yes No
F. Used laxatives, diuretics or speed Yes No
G. Self-induced vomiting after meals Yes No
H. Engaged in binge eating Yes No
I. Fasted or exercised excessively Yes No
J. In a menstruating female, missed at least three consecutive periods Yes No

9. **Recently, has your son or daughter excessively used**:

A. Alcohol	Yes	No	Occasionally	Frequently
B. Amphetamines, speed or diet pills	Yes	No	Occasionally	Frequently
C. Marihuana	Yes	No	Occasionally	Frequently
D. Any form of cocaine	Yes	No	Occasionally	Frequently
E. Sedatives, hypnotics and anxiolytics (valium, sleeping pills, etc.)	Yes	No	Occasionally	Frequently
F. Hallucinogens	Yes	No	Occasionally	Frequently
G. Inhalants	Yes	No	Occasionally	Frequently
H. Opiates (heroin, morphine, codeine, etc.)	Yes	No	Occasionally	Frequently
I. Phencyclidine (PCP, hog, tranq, angel dust, etc.)	Yes	No	Occasionally	Frequently

10. **Over the past year has your son or daughter**:

A. Exhibited a significantly irritable, depressed or sad mood lasting at least several days?
Yes No Mild Moderate Severe
B. Exhibited the loss of interest of pleasure in usual activities that he/she enjoys?
Yes No Mild Moderate Severe
C. Complained of appetite changes or sudden weight gain or loss?
Yes No Mild Moderate Severe
D. Had frequent problems with insomnia or hypersomnia (problem falling asleep/oversleeping)?
Yes No Mild Moderate Severe
E. Been significantly restless or noticeably lethargic? Yes No Mild Moderate Severe
F. Been fatigued, tired or listless nearly every day? Yes No Mild Moderate Severe
G. Felt worthless or excessively guilty (low self worth)? Yes No Mild Moderate Severe
H. Had difficulty concentrating in school or at home? Yes No Mild Moderate Severe
I. Been preoccupied with thoughts of death, suicide or attempted suicide?
Yes No Mild Moderate Severe
J. Had periods of enormous energy with little need to sleep?
Yes No Mild Moderate Severe
K. Been more talkative than usual? Yes No Mild Moderate Severe
L. Become excessively involved in pleasurable activities with negative consequences (buying sprees, sexual indiscretion, etc.)? Yes No Mild Moderate Severe

11. **Over the past year has your son or daughter**:

A. Been bothered by recurrent or persistent disturbing thoughts Yes No
B. Attempted unsuccessfully to ignore such thoughts Yes No
C. Been overly concerned with washing and cleaning, counting, checking, repeating actions and ordering Yes No

12. **In the past year has your son or daughter complained of**:

A. Frequent headaches	Yes	No	Mild	Moderate	Severe
B. Frequent backaches	Yes	No	Mild	Moderate	Severe
C. Frequent muscle aches, soreness, or tension	Yes	No	Mild	Moderate	Severe
D. Frequent stomach problems (nausea, diarrhea, etc.)	Yes	No	Mild	Moderate	Severe
E. Problems with balance or coordination	Yes	No	Mild	Moderate	Severe
F. Shortness of breath	Yes	No	Mild	Moderate	Severe
G. Dizziness or light-headedness	Yes	No	Mild	Moderate	Severe
H. Vision troubles (double vision, blindness, etc.)	Yes	No	Mild	Moderate	Severe

13. **To your knowledge, has your child been sexually victimized (fondled, sexually abused, raped**)
Yes No If yes, what age(s): _____ By whom: _____

14. **Was your child ever physically or emotional abused**? Yes No
If yes, what age(s): _____ By whom: _____

15. **Has your child recently (while not on drugs**):

A. Heard voices talking to him/her	Yes	No
B. Experienced visual hallucinations	Yes	No
C. Had bizarre or very unusual thoughts	Yes	No

16. **Please describe, as best you can, your child's personality (emotional makeup)**. Be as descriptive as you can. _____
_____

17. **Please describe what forms of discipline you have tried and how successful or unsuccessful your methods have been**. Also, do both parents discipline the same way? Are you consistent in your handling of consequences? _____
_____
_____

18. **Please describe how your child gets along with peers**? ___is very popular

___poor loser at games	___wants to run things	___afraid peers don't like him/her
___doesn't compromise easily	___has trouble making friends	___feelings easily hurt
___has many friends	___picks on other children	___shy

19. **How does your child usually get along with mother**? _____
_____

20. **How does your child usually get along with father**? _____
_____

21. **How does your child usually get along with step/adopted parents**? _____
_____

22. **What in your opinion are your child's strengths**? _____
_____

23. **Please list any medication that your child has or is presently taking for the current problem:**

Medication	Dose	Prescribing MD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

24. **List any treatment/diagnoses your child received for this problem:** _____
_____
_____

25. **List any medical problems/conditions:** _____
_____
_____

26. **List any allergies your child has:** _____
_____
_____

27. **Does your child smoke or chew tobacco**? Yes No