CHILD/ADOLESCENT FULL ASSESSMENT

Date of first assessment contact: _____

ASESSING PRACTITIONER (Name and Discipline): _____

I. IDENTIFYING INFORMATION AND SPECIAL SERVICE NEEDS

CHILD

NAME: _____ **DOB**: _____ Age: _____

Other Names Used: _____ **GENDER**: ☐ Male ☐ Female

ETHNICITY:_____ **PREFERRED LANGUAGE**: _____

Referred by (Name & Number): _____

BIOLOGICAL PARENTS & CONTACT INFORMATION

Mother's Name: _____
Marital Status: _____ DOB: _____
Address: _____
Phone: _____ Work: _____
Preferred Language: _____
Interviewed: ☐ Yes ☐ No Interpreter Used: ☐ Yes ☐ No
Language Used for Interview: _____

Father's Name: _____
Marital Status: _____ DOB: _____
Address: _____
Phone: _____ Work: _____
Preferred Language: _____
Interviewed: ☐ Yes ☐ No Interpreter Used: ☐ Yes ☐ No
Language Used for Interview: _____

PRIMARY CAREGIVER & CONTACT INFORMATION (Complete only if Biological Parent is not the Primary Caregiver)

☐ Adoptive ☐ Guardian ☐ Foster ☐ Kinship/Relative ☐ Group Home ☐ Other

Name: _____ Relationship to Child: _____ DOB: _____
Address: _____
Marital Status: _____ Phone: _____ Work: _____
Preferred Language: _____ Language Used for Interview: _____ Interpreter Used: ☐ Yes ☐ No

☐ Cultural Considerations, specify:_____
☐ Physically challenged (wheelchair, hearing, visual, etc.) specify: _____
☐ Access issues (transportation, hours), specify: _____

II. REASON FOR REFERRAL / CHIEF COMPLAINT

PRECIPITATING EVENT(S)/REASON FOR REFERRAL
CURRENT SYMPTOMS AND BEHAVIORS (INTENSITY, DURATION, ONSET, FREQUENCEY) and **IMPAIRMENTS IN LIFE FUNCTIONING** caused by the symptoms/behaviors (from perspective of client and others):

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SUICIDAL THOUGHTS/ATTEMPTS: *"Columbia Suicide Severity Rating Scale Screener (LACDMH Version)"*

Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.*

1. Within the past 30 days, have you wished you were dead or wished you could go to sleep and not wake up?
   ☐ Yes ☐ No

Suicidal Thoughts: *General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.*

2. Within the past 30 days, have you actually had any thoughts of killing yourself? ☐ Yes ☐ No

If YES to 2, ask questions 3, 4, 5, and 6
If NO to 2, go directly to question 6

Suicidal Thoughts with Method (without Specific Plan or Intent to Act): *Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period.*

3. Have you been thinking about how you might kill yourself? ☐ Yes ☐ No

Suicidal Intent (without Specific Plan): *Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts.*

4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No

Suicide Intent with Specific Plan: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.*

5. Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?
   ☐Yes ☐No

Suicidal Behavior:

6. Have you done anything, started to do anything, or prepared to do anything to end your life? ☐Yes ☐No

If yes, How long ago did you do any of these? _____

Additional comments regarding suicidal thoughts/attempts:

Self-Harm (without statement of suicidal intent) ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe:

III. MENTAL HEALTH HISTORY / RISKS

PSYCHIATRIC HOSPITALIZATIONSs: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe **DATES, LOCATION, AND REASONS**

OUTPATIENT TREATMENT: ☐ Yes ☐ No ☐ Unable to Assess
If yes, **DESCRIBE DATES, LOCATIONS, AND REASONS**

RECOMMENDATIONS, RESPONSE TO TREATMENT, PARENT/CHILD SATISFACTION

Prior Mental Health Records Requested: ☐ Yes ☐ No
Prior Mental Health Records Requested from: _____

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TRAUMA or Exposure to Trauma: ☐ Yes ☐ No ☐ Unable to Assess

Examples include: (1) physically hurt or threatened by another, (2) raped or had sex against their will, (3) lived through a disaster, (4) combat veteran or experienced an act of terrorism, (5) severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) victim of a crime

IV. MEDICATIONS

List "all" past and present psychotropic medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

MEDICATION	DOSAGE/FREQUENCEY	PERIOD TAKEN	EFFECTIVENESS/RESPONSE/SIDE-EFFECTS/REACTIONS

General Medication Comments (include significant non-psychotic medication issues/history):

V. SUBSTANCE USE Screening and Assessment

Child/Adolescent Screening Questions

Part A	Yes	No
1. During the past 12 months, did you drink any alcohol (more than a few sips)? *(Do not count sips of alcohol taken during family or religious events)*	☐	☐
2. During the past 12 months, did you smoke any marijuana or hashish?	☐	☐
3. During the past 12 months, did you use anything else to get high?	☐	☐

If the client answered "yes" to any questions in Part A, continue with Part B.

Part B		
4. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
5. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
6. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
7. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
8. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
9. Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?	☐	☐

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Assessment/Additional Information

PAST AND PRESENT USE OF TOBACCO, ALCOHOL, CAFFEIENE, CAM (COMPLEMENTARY AND ALTERNATIVE MEDICATIONS) AND OVER-THE-COUNTER, AND ILLICIT DRUGS. Be sure to include route of administration, frequency (amount), withdrawals, etc. Also, include any relevant information from other sources (i.e. teachers, social workers, etc.)

Parent/caregiver comments/concerns regarding client's relationship with alcohol or drugs:
May utilize MH552 Co-Occurring Substance Use Parent/Caregiver Questionnaire

VI. MEDICAL HISTORY

PEDIATRICIAN'S NAME: _____ **PEDIATRICIAN'S PHONE**: _____

Date of Last Physical Exam: _____

Glasses	☐ Yes ☐ No	Braces	☐ Yes ☐ No	Sensory/Motor Impairment	☐ Yes ☐ No
Seizure/Neuro Disorder	☐ Yes ☐ No	Acute Illness	☐ Yes ☐ No	Chronic Illness	☐ Yes ☐ No
Accidents	☐ Yes ☐ No	Head Trauma	☐ Yes ☐ No	Hearing Problems	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Vaccinations	☐ Yes ☐ No	Asthma/Lung Disease	☐ Yes ☐ No
Sexually Transmitted Disease	☐ Yes ☐ No	Weight or Appetite Change	☐ Yes ☐ No		

ALLERGIES ☐ Yes ☐No If yes, specify:_____ HIV Test ☐ Yes ☐ No If yes, date: _____

Pregnant ☐ Yes ☐ No If yes, date:_____

Medical Comments:

☐ Records requested from: _____

VII. DEVELOPMENTAL HISTORY

Neonatal: Prenatal Care? ☐ Yes ☐ No Term: Mos. _____ Birth Wt _____

Place of Delivery: _____ Age of Mother: _____ Age of Father:_____ Marital Status: ____

Did Mother use alcohol, cigarettes, drugs? ☐ Yes ☐ No If yes, specify:_ _____

Illness, accidents, stresses during pregnancy or at the time of pregnancy:

_____

Type of Delivery: _____ Duration of Labor: _____

Post-Partum complications: _____

Comments *(include family and environmental stressors during pregnancy and at birth)*:

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DEVELOPMENTAL MILESTONES *(Describe if not within normal limits)*		**ENVIROMENTAL STRESSORS** *(Examples include moves, school changes, loss of fam/friends, changes in fam composition, SES, lifestyle, exposure to fam conflict/violence, major illnesses, abuse/neglect, placement changes, etc.)*
Infancy (0-3) *Motor skills (sit, crawl, walk)* *Speech* *Eating* *Sleeping* *Toilet training* *Coordination* *Temperament* *Separation*		**Infancy (0-3)**
Early Years (4-6) *Social Adjustment* *Separation* *Sexual Behaviors* *Self-Care*		**Early Years (4-6)**
Latency (7-11) *School adjustment* *Peer & adult relations / friends* *Interest/hobbies* *Impulse control* *Self-Care*		**Latency (7-11)**
Adolescence (12-on) *Separation / individuation* *Sexual orientation* *Sexual behavior* *Gender identity* *Relationships / Support Systems* *Independent functioning* *Moral development*		**Adolescence (12-on)**

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VIII. PSYCHOSOCIAL HISTORY

SCHOOL HISTORY, CURRENT STATUS & ASPIRATIONS

School: _____ Grade Level: _____

Special Education: ☐ Yes ☐ No Special Classes: ☐ Yes ☐ No

IEP: ☐ Yes ☐ No Dates: _____

Educational Comments *(e.g. type of school, academic performance, grade retention, school changes, attitude/behavior, attendance/truancy, suspension/expulsion)*

VOCATIONAL INFORMATION *(e.g. jobs, independent living program, training, job related problems, volunteer work, career interests)*

JUVENILE COURT HISTORY *(e.g. arrests/offenses, tickets/warnings, probation/stipulations, incarceration, placement)*

CHILD ABUSE AND PROTECTIVE SERVICES INFORMATION *(nature of allegations, age of occurrence, offender, dependency court action, child/parent response, placement and type, services)*

DCFS or Police Intervention: ☐ Yes ☐ No Is there a current visitation/involvement plan? ☐ Yes ☐ No

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IX. CURRENT LIVING SITUATION

Living Situation Type: ☐ Biological ☐ Adoptive ☐ Guardian ☐ Foster ☐ Kinship/Relative ☐ Group Home ☐ Other

Is the client homeless? ☐ Yes ☐ No ☐ Unable to Assess

If yes, when did the client become homeless (estimated date)? _____

Others Diagnosed with Mental Illness in Living Situation: ☐ Yes ☐ No

Significant Current Drug/Alcohol Use in Living Situation: ☐ Yes ☐ No

Initial date of current living situation: _____

Family Composition *(Include siblings, stepparents/others, grandparents, extended family, ethnicity/culture, education, socio-economic, religious affiliation)*

FAMILY HISTORY:

History of Mental Illness in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess
Alcohol/Drug Use in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess
History of Incarceration in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess
Family History *(including medical, mental, substance use, legal)*

FAMILY RELATIONSHIPS *(quality of attachment, disciplinary style, conflict/violence, problem solving)*

FAMILY STRENGTHS *(client/family perspective, assessor's perspective)*

Family Needs *(client/family perspective, assessor's perspective)*

Stated Needs and Expectations
What are the family members/child expecting of mental health and interagency system? What are they willing to contribute?

X. RELEVANT PAST LIVING SITUATION

Living Situation Type: ☐ Biological ☐ Adoptive ☐ Guardian ☐ Foster ☐ Kinship/Relative ☐ Group Home ☐ Other

Others Diagnosed with Mental Illness in Living Situation: ☐ Yes ☐ No

Significant Current Drug/Alcohol Use in Living Situation: ☐ Yes ☐ No

Family Composition *(Include siblings, stepparents/others, grandparents, extended family, ethnicity/culture, education, socio-economic, religious affiliation)*

FAMILY HISTORY:

History of Mental Illness in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess
Alcohol/Drug Use in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess
History of Incarceration in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess
Family History *(including medical, mental, substance use, legal)*

FAMILY RELATIONSHIPS *(quality of attachment, disciplinary style, conflict/violence, problem solving)*

FAMILY STRENGTHS *(client/family perspective, assessor's perspective)*

Family Needs *(client/family perspective, assessor's perspective)*

Family/Child's Current Visitation & Involvement Plan and Schedule *(Complete only if client does not reside with family of origin)*

What is the family's current court-ordered visitation plan? *Include information about visits with biological parents, stepparents/siblings, extended family, if applicable. Include frequency of the visits, length, and need for monitoring.*	
Level of engagement in child's assessment	

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XI. MENTAL STATUS EXAM

Instructions: Check all descriptions that apply

Apparent Age:
☐ Younger ☐ Stated age ☐ Older
Comments:

Weight:
☐ Normal range ☐ Underweight
☐ Overweight
Comments:

Cleanliness/Grooming/Attire:
☐ Well Groomed ☐ Clean / Normal for age
☐ Disheveled / Messy
☐ Dirty / Odorous / Neglected
Comments:

Behavior
Activity Level:
☐ Normal / Age Appropriate ☐ Hyperactive
☐ Fidgety ☐ Hypoactive ☐ Lethargic
☐ Mannerisms ☐ Tics
Comments:

Gross Motor:
☐ Intact ☐ Impaired
Comments:

Fine Motor:
☐ Intact ☐ Impaired
Comments:

Behavioral Disturbances:
☐ Aggressive ☐ Poor impulse control
☐ Passive ☐ None
Comments:

Manner of Relating to Examiner – Eye Contact:
☐ Good / Age Appropriate ☐ Limited
☐ Avoided ☐ Staring
Comments:

Ability to Cooperate and Engage:
☐ Cooperative ☐ Indifferent ☐ Anxious
☐ Withdrawn ☐ Seductive ☐ Oppositional
☐ Aggressive ☐ Other:_____
Comments:

Relatedness to Caregiver:
☐ Appropriate ☐ Defiant / disobedient
☐ Clinging ☐ Bossy ☐ Not observed
Comments:

Speech and Language
Rate:
☐ Normal ☐ Rapid ☐ Pressured
☐ Slow
Comments:

Volume:
☐ Normal ☐ Loud ☐ Soft
Comments:

Clarity:
☐ Clear ☐ Slurred ☐ Mumbled
☐ Stuttered ☐ Incoherent
Comments:

Content:
☐ Normal / Age Appropriate
☐ Hyper-verbal ☐ Impoverished w/ little detail ☐ Mute / Non-verbal
Comments:

Thought Content – Delusions
☐ Persecutory ☐ Grandiose ☐ Paranoid
☐ Religious ☐ Somatic ☐ None
Comments:

Hallucinations:
☐ Auditory / Reacting to internal stimuli
☐ Visual ☐ Tactile ☐ Olfactory ☐ None
Comments:

Anxiety:
☐ Fears / Phobias ☐ Obsessions
☐ Compulsions / Rituals
☐ Separation difficulties ☐ None
Comments:

Thought Process:
☐ Normal / Linear ☐ Disorganized

If disorganized, indicate:
☐ Circumstantial ☐ Flight of ideas
☐ Paucity of ideas ☐ Rumination
☐ Tangential ☐ Loose associations
☐ Thought blocking
Comments:

Alertness / Attention and Concentration:
☐ Alert ☐ Focused
☐ Short attention span ☐ Tired / lethargic
☐ Easily distractible ☐ Other: _____
Comments:

Orientation:
☐ Oriented ☐ Disoriented

If disoriented, disoriented to:
☐ Time ☐ Place ☐ Person
Comments:

Memory:
Short-term:
☐ Intact ☐ Impaired ☐ N/A due to age
Comments:

Long-term:
☐ Intact ☐ Impaired ☐ N/A due to age
Comments:

Fund of Knowledge / Intelligence
☐ Average ☐ Above Average
☐ Below Average
Comments:

Cognitive Ability / Insight
☐ Good ☐ Poor ☐ Fair ☐ N/A due to age
Comments:

Mood:
☐ Euthymic / Normal ☐ Fearful / Anxious
☐ Angry ☐ Euphoric ☐ Sad / Tearful
☐ Irritable / Agitated ☐ Silly
☐ Other:_____
Comments:

Affect / Expression:
☐ Normal Range ☐ Incongruent w/ mood
☐ Blunted ☐ Labile ☐ Congruent w/ mood
☐ Restricted / Constricted ☐ Flat
Comments:

Examination of Risk - Suicidal
☐ Denies ☐ Admits
If suicidal, indicate:
☐ Thoughts ☐ Plan ☐ Intent ☐ Recent Attempt
Comments:

Examination of Risk - Homicidal
☐ Denies ☐ Admits
If homicidal, indicate
☐ Thoughts ☐ Plan ☐ Intent ☐ Recent Attempt
Comments:

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XII. Summary and Diagnosis

CLIENT'STRENGTHS *(to assist in achieving treatment goals)*

CLINICAL FORMULATION: *Summarize/conceptualize all clinical information to determine the client's diagnosis and include initial proposal(s) for treatment. Be sure to identify any impairments in life functioning due to the client's diagnosis (Medical Necessity). Formulation should include risk factors as well as any significant strengths that can assist the client with treatment.*

DIAGNOSTIC DESCRIPTOR

_____
_____
_____
_____
_____
_____
_____
_____
_____

ICD DIAGNOSIS CODE (check at least one Primary)

☐ Primary Code _____
☐ Sec Code _____
Code _____
Code _____
Code _____
Code _____
Code _____
Code _____
Code _____

Disposition/Recommendations/Plan:

SIGNATURE

_____	_____	_____	_____
Assessor's Signature & Discipline	**Date**	**Co-Signature & Discipline**	**Date**

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