# INFANCY, CHILDHOOD & RELATIONSHIP ENRICHMENT INITIAL ASSESSMENT

(Used for Birth -5 years)



Initial Contact Date: _____ Date Form Completed: _____
**ASSESSING PRACTITIONER** (Name and Discipline): _____

## I. IDENTIFYING INFORMATION AND SPECIAL SERVICE NEEDS

**Child Information**

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

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

**PREFERRED LANGUAGE(S)**: _____ **ETHNICITY(IES)**: _____

☐ Cultural Considerations, specify: _____

☐ Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

☐ Access issues (transportation, hours), specify: _____

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(s) are not the Primary Caregivers)

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

Date finalized: _____

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

## II. REASON FOR REFERRAL / CHIEF CONCERN

| | |
|---|---|
| **PRESENTING PROBLEM(S):** *Type of help family is hoping to receive* | |
| **CURRENT PRIMARY SYMPTOMS/BEHAVIORS** | |
| **DESCRIBE ONSET, DURATION & FREQUENCY** | |



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## III. MENTAL HEALTH HISTORY / RISKS

**PSYCHIATRIC HOSPITALIZATIONS:** ☐ 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: _____

**TRAUMA or Exposure to Trauma:** ☐ Yes ☐ No ☐ Unable to Assess
*Examples include: Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) experienced an act of terrorism, (5) been in a 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) been the victim of a crime, (8) experienced neglect, (9) experienced a referral to child protective services?*

## 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/FREQUENCY | PERIOD TAKEN | EFFECTIVENESS / RESPONSE / SIDE-EFFECTS / REACTIONS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**General Medication Comments**

**SUBSTANCE EXPOSURE / Parental Substance Use**



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## V. Physical Status / MEDICAL HISTORY

Does this client have an identified pediatrician or health care providers? □ Yes □ No
Source of Information: □ Physician Consultation/Public Health Nurse □ Medical Records □ Parent/Caregiver
Date of Last Physical: _____
**PEDIATRICIAN'S NAME**: _____ **PEDIATRICIAN'S PHONE**: _____

Acute Illness / Medical Problems (List):

Check any that apply:

□ Colic □ Failure to Thrive □ Growth Delay □ Nutritional Concerns □ Asthma □ **ALLERGIES** □ Glasses/Vision □ Endocrine Problems

□ Sensory/Motor Impairment □ Dental □ Cancer □ Ear Infections # Of Times Treated w/ Antibiotics per Year: _____

□ Immune-Suppressed □ Deafness (Partial / Total) □ Blindness (Partial / Total) □ Lead Level Tested (Date/Details) _____

Vaccination up to date? □ Yes □ No □ Other Injuries/Trauma (Type): _____

Neurological: □ Seizure Disorder □ Autism □ Cerebral Palsy □ OTHER: _____

Brain Trauma (Date/Details): _____

Chronic Health Problems/Chronic Pain:

Visible Abnormalities/Malformations *(Head, Hands, Spine, Extremities, Face, Genitalia, Skin):*

History of Medical Procedures and/or Hospitalizations (NICU, surgeries) and the impact on child/dyad/family:

Details Regarding Above/Other Medical Comments:

## VI. DEVELOPMENTAL HISTORY *(DC: 0-5: Axis V)*

**Prenatal/Perinatal Information**

Prenatal Care: □ None □ Intermittent □ Regular □ Other: _____

Prenatal Complication/Concerns *(Illnesses, accidents, stressors during pregnancy such as homelessness/domestic or interpersonal violence, parental use of alcohol, drugs, cigarettes, parental mental health):*

Postpartum Psychiatric Problems *(examples include anxiety, depression, psychosis, suicidal/homicidal ideation):* □ Yes □ No
General Comments:

**Birth History**

Term (weeks): _____ Birth Weight (lb./oz.): _____ Birth Length (inches): _____ Mom's Age: _____

Labor Duration: _____ Child Days in Hospital: _____ Place of Delivery: _____ Dad's Age: _____

Type of Birth: □ Vaginal □ Induced □ C-Section □ Forceps □ Vacuum Type of Anesthesia Used: _____
Birth History Comments *(complications, perceptions of birth, length of NICU stay, if applicable):*

**Parent/Caregiver Perceptions of Pregnancy & Birth** *(Planned or surprise? Your/partner's reaction? Support?)*



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| | |
|---|---|
| Breast-fed/Bottle-fed/Combination? Duration and age weaned?<br><br>Age of taking cereal, solids. Types?<br><br>Feeding difficulties *(include frequency & onset)* such as spitting up, sucking problems, refusal to eat, over-eating, fussy eater, GERD, Pica, Rumination, hoarding<br><br>Food Aversions?<br><br>Eating schedule/Frequency of eating<br><br>Any weight or appetite changes?<br><br>Signals of hunger/satiation? Self-regulation? | **Feeding** |
| Where does the child sleep? Does that work for you and your family?<br><br>Good sleeper? How did s/he sleep in past week? Last night? Is this typical?<br><br>Is there a sleep routine/schedule?<br><br>Length and frequency of naps, nighttime sleep?<br><br>Sleep concerns *(e.g. difficulty falling asleep, waking, nightmares, night terrors, bed wetting, excessive snoring)*<br>Frequency & onset<br><br>Any sleep-related interventions attempted *(e.g. sleep training, sleep study)?* | **Sleeping Patterns** |
| Describe your child's temperament:<br>Examples:<br>• Easy going = flexible, positive, calm, sustained attention<br>• Slow to Warm Up = needs time to adjust; fussy, worried or timid at first but easy going once comfortable<br>• Difficult = transitions are difficult, resists change, quick to cry, easily frustrated<br><br>Is it easy for your child to transition from one activity to another?<br><br>Is your baby colicky, fussy, cries a lot? How often & how long does your baby cry?<br><br>Is it easy to read your baby's signals and moods?<br><br>How responsive is your baby to you? Easy or difficult to soothe? What soothing strategies work best?<br><br>Child's ability to self-regulate? | **Temperament / Regulation** |



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***See Reference Manual***

| **DEVELOPMENTAL MILESTONES**<br>*(Describe if not w/in normal limits and address the following domains: sensory, motor, socio-emotional, language, cognitive and adaptive/self-help)* | | **ENVIRONMENTAL STRESSORS**<br>*(Examples include moves, schools changes, separation, losses of family/friends, changes in family composition, SES, lifestyle, exposure to family conflict/violence, major illnesses, abuse/neglect, placements, etc.)* |
|---|---|---|
| **Infancy: 0-6 months**<br>*Smiles back*<br>*Rolls over*<br>*Turns to sound*<br>*Babbles*<br>*Plays with objects* | | **0-6 months.** |
| **6-12 months**<br>*Stranger anxiety*<br>*Sits upright/walks*<br>*Responds to name*<br>*Object constancy*<br>*Says 1-2 words* | | **6-12 months** |
| **12-18 months**<br>*Reciprocal play*<br>*Eats with spoon*<br>*Tolerates noises*<br>*Jumps with 2 feet*<br>*Says 4-6 words* | | **12-18 months** |
| **18-24 months**<br>*Words for feeling*<br>*Balances on 1 foot*<br>*Brushes teeth/hair*<br>*2-3 word sentences*<br>*Pretend play* | | **18-24 months** |
| **24-36 months**<br>*Toilet trained?*<br>*Throws ball*<br>*Uses "I"*<br>*2-step request*<br>*Uses "big/little"* | | **24-36 months** |
| **36-60 months**<br>*Uses scissors*<br>*Climbs a ladder*<br>*Uses sentences*<br>*Draws a line*<br>*Symbolic play* | | **36-60 months** |

**Development Assessment Tools & Results**

Were the Ages and Stages Questionnaires completed? ☐ **Yes** ☐ **No**

If yes, enter the following Domain Scores:

Communication: _____
Gross Motor: _____
Fine Motor: _____
Problems Solving: _____
Personal-Social: _____
Comments:

Has any other developmental screening been conducted? ☐ **Yes** ☐ **No**

Comments regarding type and results:



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## VII. PSYCHOSOCIAL HISTORY

**Current Daycare, Child Care, Or School**

□ Does Not Attend Child Care □ Attends Licensed Day Care □ Attends Unlicensed Child Care □ Cared for by Relatives
□ Currently Not Enrolled in Preschool □ Special Education Program

Child Care/Preschool Name: _____
Contact Person: _____
Address: _____
Phone: _____
Days/Times Per Day Child Attends: _____
Parent Participation: _____
Notable Info: _____
Date Of Last IFSP/IEP: _____
IFSP/IEP Eligibility: _____

Additional Child Care: _____
Contact Person: _____
Address: _____
Phone: _____
Days/Times Per Day Child Attends: _____
Parent Participation: _____
Quality Of Relationships With Peers And Staff:_____
_____

**Early Intervention**

□ Currently Not In Early Intervention Program
Date Enrolled: _____
Name Of Program: _____
Contact Person: _____
Address: _____
Phone: _____
Days/Times Per Day Child Attends: _____
Services Receiving: _____
Parent Participation: _____
Quality Of Relationships With Peers And Staff: _____

□ History Of Early Intervention Program
Date Enrolled: _____
Name Of Program: _____
Contact Person: _____
Address: _____
Phone: _____
Days/Times Per Day Child Attends: _____
Services Receiving: _____
Parent Participation: _____
Quality Of Relationships With Peers And Staff: _____

**Regional Center Services**

☐ N/A ☐ Found Not Eligible ☐ Current Regional Center Client ☐ Never Evaluated

Regional Center Name: _____ Contact Person: _____
Address: _____Phone: _____
Days/Times Child Attends: _____ Type Of Classroom: _____
Date Of Last IPP: _____ Regional Center Eligibility: _____
Regional Center Services And Hrs/Week: _____
Quality Of Relationships With Peers And Staff:_____

**History of Child Care / Early Intervention / Preschool or Special Services**
*(Consider: licensed/unlicensed facility, #children in class, age range of children, nature of relationship with teachers/caregivers, peer relationships, parents' perception of support from teachers/caregivers, history of threatened or actual suspensions or expulsions from day care/pre-K, etc.)*

**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

Family Visitation & Involvement Plan/Visitation schedule/Engagement in child's assessment:



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## VIII. CURRENT FAMILY SYSTEMS REVIEW

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

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

**Family Members Living in Child's Current Home** (*Identify relation & age)*

| | |
|---|---|
| Who else lives in your home?<br>Apt/house? Enough space?<br>Always lived here?<br><br>**FAMILY RELATIONS**<br>Get along with each other?<br>Extended family?<br>Friends?<br><br>**SOCIAL/ OTHER SUPPORTS?**<br>DCFS support?<br><br>**FAMILY HISTORY**:<br>Medical<br>Psychiatric<br>Legal/Criminal<br>Alcohol/Drug<br><br>Family cultural identity?<br>Immigration history?<br>Religion? Spiritual practice?<br><br>**FAMILY STRENGTHS?** | |

## IX. RELEVANT PAST FAMILY SYSTEMS REVIEW *(complete only if client has had more than one Relevant Family System)*

**Family Members Not Currently Living in Child's Home**
*(Identify relation & age)*

| | |
|---|---|
| Who else lives in your home?<br>Apt/house?<br>Enough space?<br>Always lived here?<br><br>**FAMILY RELATIONS**<br>Get along with each other?<br>Extended family?<br>Friends?<br><br>**SOCIAL/OTHER SUPPORTS?**<br>DCFS support?<br><br>**FAMILY HISTORY**:<br>Medical<br>Psychiatric<br>Legal/Criminal<br>Alcohol/Drug<br><br>Family cultural identity?<br>Immigration history?<br>Religion? Spiritual practice?<br><br>**FAMILY STRENGTHS?** | |



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## X. Observed Caregiver – Child Interaction *(Refer to the DC:0-5 Manual, Axis II Relational Context)*

| | |
|---|---|
| Be sure to address relevant features from each **bolded** category below.<br><br>**Behavioral Observations**<br>Ensuring physical safety<br>Eye contact; physical contact<br>Affective tone<br>Enjoyment in joint play<br>Teaching/providing structure/socializing<br>Supporting child's developmental capacity<br>Appropriate limit-setting<br>Tolerating ambivalent feelings<br><br>**Attunement, Balance & Congruence**<br>Response to child's emotional needs/cues<br>Comfort when distressed<br>Showing interest in child's experience and incorporating (e.g., following child's lead) | Provide a description based on your observations of child & caregiver interaction. |

## XI. Behavioral Observations & Interview w/ Caregiver

| | |
|---|---|
| Be sure to address relevant features from each **bolded** category below.<br><br>**Behavioral Observations**<br>Appearance, manner of relating, expressive style, mood/affect<br><br>**Caregiver's Perceptions and Expectations**<br>Of the child/baby, of his/herself and parenting, and of treatment<br><br>**Insight/Strengths/Challenges**<br>Adaptive capacity, strengths & assets, cooperation, insight, judgment, motivation for treatment<br><br>**Relationship Between Caregivers**<br>Problem-solving<br>Views of problem/strengths in child<br>Communication between caregivers<br>Conflict resolution<br>Emotional investment in each other<br>Behavioral regulation and coordination | Provide a description based on your observations of child & caregiver interaction. |



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## XII. MENTAL STATUS / Behavioral Observations: Child *(See ICARE Reference Manual)*

Include relevant features from below. Be sure to address relevant features from each **bolded** category below.

**Appearance**
Dress, grooming, unusual physical characteristics

**Behavior**
Activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

**Socio-Emotional/Mood/Affect**
Shy, fearful, labile, sad, blunt, irritable, aggressive, passive, depressed, anxious, risk to self or others, slow to warm up, easy going, difficult, ability to co-regulate and ability to self-regulate, frustration tolerance (e.g., reaction to transitions/adaptation)

**Risk to Self/Others**

**Thought Content**
Expressing worrisome thoughts, expressing developmentally inappropriate fantasies

**Cognitive**
Attention span and play are age appropriate, problem-solving ability

**Communication/Language**
Verbal/nonverbal, receptive/expressive, age appropriate, emotional expression

**Sensorimotor**
Visual, auditory, tactile, vestibular, proprioceptive, taste, textures, smells (over-reactive, under-reactive, typical), reaction to stimuli

**Gross Motor/ Fine Motor**
Coordination, motor planning, postural stability**,** coordination, tremors

**Muscle Tone**
Low, floppy, tense

**Adaptive Functioning**
Age appropriate self-care, feeding, toileting

**Play**
(e.g., parallel play, cooperative play)

**Unusual Behaviors**
(e.g., Repetitive behaviors, head-banging, breath-holding)

**Strengths**
Adaptive capacity, strengths & assets, cooperation

Provide a description of this child based on your observations.



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## XIII. SUMMARY / CLINICAL FORMULATION / DIAGNOSIS

**STRENGTHS OF THE CHILD AND FAMILY** *(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. Identify any impairments in life functioning due to the client's diagnosis, if applicable, or how Specialty Mental Health Services can assist the client. Formulation should include risk factors as well as any significant strengths that can assist the client with treatment. Cultural factors related to the client's presenting problems, psychosocial and caregiving environment, and relationship between parents/caregivers should be considered, in addition to probability of not meeting socio-emotional developmental milestones, likelihood of later deterioration in functioning if not in services and impact on family.*

| ***DC:*0-5 Diagnosis (Please refer to the DC: 0-5 Manual):** | ***ICD 10* DIAGNOSIS CODE: (To be entered in IBHIS)** |
|---|---|
| **Axis I** (Clinical Disorders): | **Primary:** _____<br>**Secondary:** _____<br>**Other:** _____ |

**Axis II** : (Relational Context) *Consider v/z-codes in the Comments Section*:

**Levels of Adaptive Functioning – Caregiving Dimension**

Caregiver 1 (choose one)
- ☐ Level 1 – Well-adapted to Good-Enough Relationships
- ☐ Level 2 – Strained to Concerning Relationships
- ☐ Level 3 – Compromised to Disturbed Relationships
- ☐ Level 4 – Disordered to Dangerous Relationships

Caregiver 2 (choose one)
- ☐ Level 1 – Well-adapted to Good-Enough Relationships
- ☐ Level 2 – Strained to Concerning Relationships
- ☐ Level 3 – Compromised to Disturbed Relationships
- ☐ Level 4 – Disordered to Dangerous Relationships

**Levels of Adaptive Functioning – Caregiving Environment**

Caregiving Environment (choose one)
- ☐ Level 1 – Well-adapted to Good-Enough Caregiving Environment
- ☐ Level 2 – Strained to Concerning Caregiving Environment
- ☐ Level 3 – Compromised to Disturbed Caregiving Environment
- ☐ Level 4 – Disordered to Dangerous Caregiving Environment

Comments:

**Axis III** (Physical Health Conditions/Considerations):

**Axis IV** (Psychosocial Stressors) *Consider severity and buffers*:



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***DC: 0-5 Diagnosis continued***
**Axis V** (Developmental Competence):

| **Competency Domain Rating** | **Emotional** | **Social-Relational** | **Language-Social Communication** | **Cognitive** | **Movement and Physical** |
|---|---|---|---|---|---|
| Exceeds developmental expectations | ☐ | ☐ | ☐ | ☐ | ☐ |
| Functions at age-appropriate level | ☐ | ☐ | ☐ | ☐ | ☐ |
| Competencies are inconsistently present or emerging | ☐ | ☐ | ☐ | ☐ | ☐ |
| Not meeting developmental expectations (delay or deviance) | ☐ | ☐ | ☐ | ☐ | ☐ |

**XIV. Disposition/Recommendation/Plan** *(Consider collaboration between systems and providers and its impact on the child and family)*

## XIV. Referrals Given

Service: _____

Referred To: _____

Date: _____ Contact Name: _____ Phone Number: _____

Service: _____

Referred To: _____

Date: _____ Contact Name: _____ Phone Number: _____

Service: _____

Referred To: _____

Date: _____ Contact Name: _____ Phone Number: _____

## XV. SIGNATURES

_____ _____ _____ _____
ASSESSOR'S SIGNATURE TITLE DISCIPLINE DATE

_____ _____ _____ _____
CO-SIGNATURE TITLE DISCIPLINE DATE



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