GLIO COUNSLEING GROUP, PLC
CHILD PSYCHOSOCIAL ASSESSMENT

GENERAL INFORMATION:

Date: ____________ Client: ____ ☐ M ☐ F

Age: _______ Date of Birth: ________________

Why are you seeking treatment at this time? ____

FAMILY HISTORY:

Who is the child being raised by (check all that apply): ☐ Biological Mother ☐ Biological Father

☐ Stepmother ☐ Stepfather ☐ Other: ____

If parents are divorced, who has legal custody? ____________________ Physical custody? ___________

What is the custody arrangement? ____

How many brothers and sisters does your child have? _____Brothers _____Sisters

Briefly describe how your child gets along with others in your family? (Brothers, sisters, parents)

Are there any family members you thought may have or have been diagnosed with a mental illness?

☐ No ☐ Yes. If yes, who and what kind of illness?

____

(including ADHD, anxiety and depression)

Have any family member committed suicide? ☐ No ☐ Yes, Who? __________________Year? _______

Is there a history of drug and/or alcohol problems in the family? ☐ No ☐ Yes

Who? ___________________________ What substance? ____________________________________

Has your child witnessed or experienced any physical or emotional abuse? If yes, please explain:

____

Has your child ever been sexually abused? ☐ No ☐ Yes if yes, please explain:

____

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

CULTURAL & RELIGION:

Does your family identify with a particular ethnic group? ☐ No ☐ Yes (please name):
____

Does your family identify with a particular religious group? ☐ No ☐ Yes, which one?
____

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

EDUCATION HISTORY:

What school does your child attend? _______________________________What grade? ____________

Any Learning Disabilities? ☐ No ☐ Yes (please explain): ____

Check all that apply regarding your child's school experience: ☐ gifted classes ☐ special education

☐ School suspensions ☐ problems with classmates/teachers

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

MEDICAL HISTORY

What is the name of your child's Doctor? ____

What medical issues does your child currently have? ____

How do you rate their general health? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

What medications are currently prescribed? ____

Please explain if your child has had any head injuries or loss of consciousness: _____________________

Does your child have difficulty falling asleep? ☐ No ☐ Yes staying asleep? ☐ No ☐ Yes

Does your child have nightmares/night terrors? ☐ No ☐ Yes

Has there been any changes in eating habits/appetite? ☐ No ☐ Yes any recent weight loss/gain? ☐ No ☐ Yes

Is there any other significant medical history? ____

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

DEVELOPMENTAL HISTORY

Were there any complications during or after pregnancy and delivery? ☐No ☐Yes

At what age did your child begin to walk? ___________________________

At what age did your child begin to say single words? _________________

Simple sentences/phrases? _______________________________________

Has your child ever had speech and language therapy? ☐No ☐Yes If yes, at what age? ___________

Has there been a history of bed wetting? ☐No ☐Yes

Has there been a history of soiling or urinating in pants? ☐No ☐Yes

Does your child have frequent headaches or stomach aches? ☐No ☐Yes

Who usually disciplines your child? ____

What disciplinary methods are used? ____

How does your child usually react to discipline? ____

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

LEGAL and SUBSTANCE USE HISTORY:

Has your child ever been arrested, convicted or placed on probation as a juvenile? ☐ No ☐ Yes

If yes, age? ________________ Offense: _________________________________

Do you have any concerns that your child may have tried or is using any illegal substances ☐ No ☐ Yes

Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

PSYCHIATRIC HISTORY

Has your child ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes if yes, where and when

____

Has your child been in counseling before? ☐ No ☐ Yes If yes, what type and when?

____

Please check categories you are concerned about in your child:

☐ Depression ☐ Thoughts of Homicide ☐ Thoughts of Suicide

☐ Anxiety/worried/nervous ☐ Sudden Mood Changes ☐ Overly Dependent

☐ Anger Control Problems ☐ Hallucinations (hearing voices or seeing things)

☐ Not liking self ☐ Withdrawal from others ☐ Overly Suspicious

☐ Problems with: ☐ Parents ☐ Siblings ☐ Friends ☐ Other Adults

☐ Poor Hygiene ☐ Overly sensitive to loud sounds, textures or smells

Please check any additional categories in which you are having difficulty in:

☐ Suicide Attempts ☐ Obsessions or Compulsions ☐ Serious Trauma ☐ Self-Abusive Behaviors

Please Explain: ____

Do you have any concerns about your child's behavior? ______________________________

Psychiatric Assessment/Clinician's Assessment: ☐ Treatment Issue ☐ Not a Treatment Issue

____ ____________________

Parent/Guardian Signature Date

CLINICIAN USE ONLY

GLIO COUNSELING GROUP PLC

MENTAL STATUS:

MOOD:	DEPRESSED	EUTHYMIC	ELATED	ANXIOUS	IRRITABLE
AFFECT:	APPROPRIATE	INAPPROPRIATE	____________________		
ACTIVITY:	NORMAL	HYPERACTIVE	HYPOACTIVE	RESTLESS	
THINKING:	NORMAL	ORGANIZED	DISORGANIZED	EVASIVENESS	
ORIENTATION:	NORMAL	CONFUSED			
PERCEPTION:	NORMAL	IMPAIRED	ILLUSIONS	HALLUCINATIONS	

PRESENTING ISSUES:

DIAGNOSTIC IMPRESSION:

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

TX GOALS:

CLINICIAN'S SIGNATURE ____ DATE ___________________