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GOFFSTOWN, NH 03045

CHILD CLINICAL ASSESSMENT

DATE COMPLETED:

CLIENT NAME: _____

CLIENT DOB: _____ CLIENT AGE: _____

PARENTS OR GUARDIAN: _____

CURRENT CUSTODY ARRANGEMENT: _____

PRESENTING PROBLEM: _____

HISTORY OF MENTAL HEALTH TREATMENT/SERVICES: _____

HISTORY OF MENTAL HEALTH ISSUES IN FAMILY: _____

FUNCTIONAL IMPAIRMENT (S): _____

DEVELOPMENTAL HISTORY: _____

PEER RELATIONSHIPS: _____

USE OF DRUGS OR ALCOHOL: _____

FAMILY MEMBERS/AGES: _____

(GENOGRAM ON BACK)

PRIMARY CARE PHYSICIAN: _____

MEDICAL CONDITIONS: _____

MEDICATIONS; _____

EDUCATION (SCHOOL NAME, GRADE, CODING, ACADEMIC STANDING):

EXTRA CURRICULAR ACTIVITIES: _____

STRENGTHS: _____

SUPPORT SYSTEM: _____

CHURCH INVOLVEMENT: _____

DIAGNOSIS:

AXIS I: (CLINICAL DISORDER) _____

AXIS II: (PERSONALITY DISORDER) _____

AXIS III: (HEALTH) _____

AXIS IV:

<input type="checkbox"/> RELATIONSHIP CONFLICT	<input type="checkbox"/> PROBLEM PREGNANCY	<input type="checkbox"/> DRUG MISUSE
<input type="checkbox"/> DIAGNOSED MENTAL ILLNESS	<input type="checkbox"/> PROBLEMS OR CONFLICT IN SCHOOL	<input type="checkbox"/> ALCOHOL MISUSE
<input type="checkbox"/> CHILD CARE PRACTICES	<input type="checkbox"/> EMOTIONAL SYMPTOMS/COMPLAINTS	<input type="checkbox"/> CHILD'S BEHAVIOR
<input type="checkbox"/> PHYSICAL COMPLAINTS	<input type="checkbox"/> INADEQUATE FOOD, CLOTHING, SHELTER	
<input type="checkbox"/> DIVORCE ADJUSTMENT	<input type="checkbox"/> PHYSICAL VIOLENCE BETWEEN ADULTS	
<input type="checkbox"/> REPORTED CHILD ABUSE, NEGLECT OR PARENTAL ALCOHOLISM		
<input type="checkbox"/> OTHER _____		

AXIS V: (GLOBAL ASSESSMENT OF FUNCTIONING: _____

RECOMMENDATIONS FOR THERAPY (IND/GRP/FAMILY): _____

REFERRALS: _____

PARENT/CLIENT SIGNATURE: _____ DATE: _____

CLINICIAN SIGNATURE: _____ DATE: _____