Family Based Therapy Associates

Pediatric Diagnostic Assessment – Parent

Please provide the following information in preparation for your interview with your mental health clinician.

Client Information	Date:	
Child Name	Date of Birth	Client Number
Referral Resource		
Reason for Referral		

Place of Birth/Previous Places of Residence for the Child

Current Living Situation

☐ Parent's Home	☐ Residential Care/Treatment Facility **	☐ Other **
☐ Rent	☐ Hospital	☐ Friend's Home
☐ Own	☐ Temporary Housing	☐ Relative/Guardian's Home
	☐ Residential Care	☐ Homeless
	☐ Nursing Home	
**Identify Person's Name or Facility		

Primary Household					
Household Member Name	**Relationship to Child**	**Age**	**Occupation/School**	**Highest Level of Education**	**Quality of Relationship**
Street Address (If different from child's address listed on Demographic information form.)					

Secondary Household					
Household Member Name	**Relationship to Child**	**Age**	**Occupation/School**	**Highest Level of Education**	**Quality of Relationship**
Street Address (If different from child's address listed on Demographic Information form.)					
Family members who live in both households ☐ Only Child ☐ Child and (list):					
Additional Family Members ☐ No parents or siblings other than those listed in primary or secondary households ☐ Yes, list the family members:					
Custody and Parenting Plan ☐ Lives with both parents (biological or adoptive) in same household ☐ Single parent ☐ Shared Custody – parents in different households ☐ Other (describe):					

Developmental Issues

Have you ever had concerns about the following issues with this child?

Pregnancy	
Had bleeding during first three (3) months	☐ Yes ☐ No ☐ Unknown
Had bleeding during second three (3) months	☐ Yes ☐ No ☐ Unknown
Had bleeding during last three (3) months	☐ Yes ☐ No ☐ Unknown
Had toxemia	☐ Yes ☐ No ☐ Unknown
Had to take medications Specify any medications:	☐ Yes ☐ No ☐ Unknown
Got injured or hurt	☐ Yes ☐ No ☐ Unknown
Gained less than 15 lbs. (7 kgs.) Specify:	☐ Yes ☐ No ☐ Unknown
Took narcotic drugs	☐ Yes ☐ No ☐ Unknown
Drank alcohol	☐ Yes ☐ No ☐ Unknown
Had an infection	☐ Yes ☐ No ☐ Unknown

Smoked during pregnancy		☐ Yes ☐ No ☐ Unknown	
Length of pregnancy: months			
Other pregnancy problems/illnesses Specify:		☐ Yes ☐ No ☐ Unknown	
Birth/Early Infancy			
Born prematurely		☐ Yes ☐ No ☐ Unknown	
Born with cord around neck		☐ Yes ☐ No ☐ Unknown	
Injured during births		☐ Yes ☐ No ☐ Unknown	
Had trouble breathing		☐ Yes ☐ No ☐ Unknown	
Turned blue (Cyanosis)		☐ Yes ☐ No ☐ Unknown	
Was a twin or triplet		☐ Yes ☐ No ☐ Unknown	
Had an infection		☐ Yes ☐ No ☐ Unknown	
Had seizures (fits, convulsions)		☐ Yes ☐ No ☐ Unknown	
Needed oxygen		☐ Yes ☐ No ☐ Unknown	
Exposure to lead		☐ Yes ☐ No ☐ Unknown	
Was very jittery		☐ Yes ☐ No ☐ Unknown	

Functioning		If yes, age first noted	If yes, still occurring?
Poor appetite	☐ Yes ☐ No ☐ Unknown		
Constipation	☐ Yes ☐ No ☐ Unknown		
Stomach aches	☐ Yes ☐ No ☐ Unknown		
Trouble falling asleep	☐ Yes ☐ No ☐ Unknown		
Trouble staying asleep	☐ Yes ☐ No ☐ Unknown		
Overactivity	☐ Yes ☐ No ☐ Unknown		
Head banging	☐ Yes ☐ No ☐ Unknown		
Rocking in bed	☐ Yes ☐ No ☐ Unknown		
Temper tantrums	☐ Yes ☐ No ☐ Unknown		
Self-destructive behavior	☐ Yes ☐ No ☐ Unknown		
Difficulty in being comforted or consoled	☐ Yes ☐ No ☐ Unknown		
Stiffness or rigidity	☐ Yes ☐ No ☐ Unknown		
Looseness or floppiness	☐ Yes ☐ No ☐ Unknown		
Crying often and easily	☐ Yes ☐ No ☐ Unknown		
Shyness with strangers	☐ Yes ☐ No ☐ Unknown		
Irritability	☐ Yes ☐ No ☐ Unknown		
Extreme reaction to noise or sudden movement	☐ Yes ☐ No ☐ Unknown		
Attention Problems		If yes, age first noted	If yes, still occurring?
Can concentrate for only a short time unless things are very interesting	☐ Yes ☐ No ☐ Unknown		
Understands the main ideas of things but misses important details	☐ Yes ☐ No ☐ Unknown		
Does work or performs many tasks carelessly without thinking	☐ Yes ☐ No ☐ Unknown		
Learns a new skill well one day and then can't seem to do it a few days later	☐ Yes ☐ No ☐ Unknown		
Receives very unpredictable (inconsistent) grades or rest scores in school	☐ Yes ☐ No ☐ Unknown		
Can work well only on things he/she really	☐ Yes ☐ No ☐ Unknown		

enjoys doing or thinking about			
Often doesn't notice when he/she makes mistakes	☐ Yes ☐ No ☐ Unknown		
Seems not to realize when he/she is disturbing someone	☐ Yes ☐ No ☐ Unknown		
Doesn't do much better after punishment or correction	☐ Yes ☐ No ☐ Unknown		
Makes comments about or is distracted by background noises or unimportant things	☐ Yes ☐ No ☐ Unknown		
Seems to want things right away and/or is hard to satisfy	☐ Yes ☐ No ☐ Unknown		
Annoys or bothers other children	☐ Yes ☐ No ☐ Unknown		
Behavior is variable and hard to predict	☐ Yes ☐ No ☐ Unknown		
Is a troublemaker; bullies others	☐ Yes ☐ No ☐ Unknown		
Behaviors	If yes, age first noted	If yes, still occurring?	
Has bad dreams	☐ Yes ☐ No ☐ Unknown		
Is often very quiet or withdrawn	☐ Yes ☐ No ☐ Unknown		
Is often "down" on himself/herself	☐ Yes ☐ No ☐ Unknown		
Is often tired	☐ Yes ☐ No ☐ Unknown		
Speaks unclearly, stutters, or stammers	☐ Yes ☐ No ☐ Unknown		
Wets bed or pants often	☐ Yes ☐ No ☐ Unknown		
Soils underwear or has accidents with bowel movements	☐ Yes ☐ No ☐ Unknown		
Is often too neat or orderly	☐ Yes ☐ No ☐ Unknown		
Is often too concerned about cleanliness	☐ Yes ☐ No ☐ Unknown		
Often plays with matches	☐ Yes ☐ No ☐ Unknown		
Destroys objects at home	☐ Yes ☐ No ☐ Unknown		
Destroys objects away from home	☐ Yes ☐ No ☐ Unknown		
Is fearless	☐ Yes ☐ No ☐ Unknown		
Is cruel to animals	☐ Yes ☐ No ☐ Unknown		
Is not liked by other children	☐ Yes ☐ No ☐ Unknown		
Feels ill on school mornings	☐ Yes ☐ No ☐ Unknown		
Has eating problems (either overeats or undereats)	☐ Yes ☐ No ☐ Unknown		
Is preoccupied with food or diet	☐ Yes ☐ No ☐ Unknown		
Is part of a clique or gang that causes trouble	☐ Yes ☐ No ☐ Unknown		
Other behaviors not noted above:	☐ Yes ☐ No ☐ Unknown		
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?	☐ Yes ☐ No ☐ Unknown		
Have you ever had concerns about your child's sexual development or behaviors?	☐ Yes ☐ No ☐ Unknown		
If there are indications of issues, please explain:			

Child's School Functioning

Education Classification	
Does your child receive special education services?	☐ Yes ☐ No
If no, has your child ever been tested and determined not to need services?	☐ Yes ☐ No
Regular education classroom, no special services If no, check all that apply below. ☐ Early Childhood Spec. Ed./Developmental Delay ☐ Special Learning Disability ☐ Hearing Impaired ☐ Visually Impaired ☐ Speech or Language Impaired ☐ Physically Impaired ☐ Emotional/Behavioral Disorder ☐ Developmental/Cognitive Disability ☐ Special Learning Disability ☐ Autism Spectrum Disorder ☐ Traumatic Brain Injury ☐ Other Health Impaired ☐ Unsure ☐ Current 504 Plan ☐ Other:	☐ Yes ☐ No
Comments on Education Classification/Placement (also please indicate if child is home schooled, in gifted program, etc.)	

Grades	☐ No problems with grades	☐ Problems with grades
In what subjects is the student (child) doing well?		
Attendance	☐ No Problems reported	☐ Problems reported
Previous Grade	☐ None reported	☐ Yes
Retentions		
Suspensions/Expulsions	☐ None reported	☐ Yes
Other Academic/School Concerns (including performance/behavioral problems due to A&D use)		
Barriers to Learning	☐ None reported	☐ Yes

Child's/Family's Religious Affiliation

Child's Legal History

Current Legal Status
☐ None reported ☐ On Probation ☐ Detention ☐ On parole ☐ Awaiting charges ☐ Substance Abuse ☐ Court-ordered to treatment ☐ Other

Specify (nature of the legal charges, county, probation officer, facility)

Past Legal Status

☐ On probation ☐ Detention ☐ Substance abuse ☐ Court-ordered to treatment ☐ Other

Child's Social Supports

Child's Leisure Activities/Employment

Major Activities Outside of the School Day

Child's Trauma History

Has your child ever experienced any of the following?

☐ Physical Abuse
☐ Domestic Violence/Abuse
☐ Physical Neglect
☐ Emotional Abuse
☐ Sexual Abuse/Molestation
☐ Community Violence
☐ None of the above

Child's Mental Health Treatment History

Previous Mental Health Treatment ☐ No ☐ Yes

If yes, please list reason for treatment, provider, and dates:

Currently on any medication(s)? ☐ No ☐ Yes

If yes, please list and bring medications to next appointment

Primary Care Physician			Phone Number	
Address	City		State	Zip Code
Other Prescribing Physician(s)			Phone Number	
Address	City		State	Zip Code

Child's Alcohol and Drug History

Question		
Do you have any concerns about your child's use of alcohol or drugs?	☐ No	☐ Yes
Do you have any other issues or concerns about your child you would like to have addressed?	☐ No	☐ Yes
Comments:		

Family Environment/Relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client Relationship(s)	**P= Primary household**		**S = Secondary household**		**B = Both**
Parent-child conflict	None-Mild	Moderate	Severe		
Issues with supervision and monitoring of child	Always	Usually	Inconsistently	Rarely	
Cooperation between parents regarding child-rearing	Always	Usually	Inconsistently	Rarely	Not Pertinent
Parent positive activities with child	Frequent	Occasionally	Infrequent		
Parent satisfaction with relationship	Satisfied	Neutral	Dissatisfied		
Child satisfaction with relationship	Satisfied	Neutral	Dissatisfied		
Comment on Parent-Child Relationships (describe further if needed)					

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (Client) Relationship(s)	☐ No Siblings		
P = Primary household	**S = Secondary household**	**B = Both**	
Child-Sibling conflict	None-Mild	Moderate	Severe
Sibling(s) positive activities with child	Frequent	Occasional	Infrequent
Sibling(s) satisfaction with relationship	Satisfied	Neutral	Dissatisfied
Child satisfaction with relationship	Satisfied	Neutral	Dissatisfied
Comment on Sibling-Child Relationships (describe further if needed)			

Please indicate below the best description of parent relationships.

Parent Marital or Couple Relationship(s)	☐ Not Applicable		
P = Primary household	**S = Secondary household**	**B = Both**	
Marital or couples conflict	None-Mild	Moderate	Severe
Marital or couples satisfaction	Satisfied	Neutral	Dissatisfied
Comment on Parent Marital or Couples Relationships (describe further if needed)			

Other Family Concerns		If yes, indicate:		
		Parent	**Sibling**	**Other**
Family member health problems	☐ No ☐ Yes	☐	☐	☐
Family member disability	☐ No ☐ Yes	☐	☐	☐
Family member legal issues	☐ No ☐ Yes	☐	☐	☐
Family financial concerns	☐ No ☐ Yes	☐	☐	☐
Family member alcohol abuse	☐ No ☐ Yes	☐	☐	☐
Family member substance abuse	☐ No ☐ Yes	☐	☐	☐
Family member anxiety	☐ No ☐ Yes	☐	☐	☐
Family member depression	☐ No ☐ Yes	☐	☐	☐
Family member ADHD	☐ No ☐ Yes	☐	☐	☐
Family member mania	☐ No ☐ Yes	☐	☐	☐
Family member schizophrenia/other psychosis	☐ No ☐ Yes	☐	☐	☐
Comment on Other Family Concerns and information Relating to Financial Status (specify problems that impact child’s needs)				

Signature: ________________________________