PARENT/GUARDIAN ASSESSMENT

Date:_________

Name of child: ____ Age: ___ Birth Date: __________

Name/s of parent/s or guardian/s completing form:____

Do all legal guardians approve of therapy for the child? (Required.) Yes _____ No _______

1. **Parents/Guardians: Please list your child's strengths/areas that are going well:**

2. **Please check your top priority concerns for your child, and a brief description.**

Concerns (check those that apply.)	**Describe: For how long,** how often/triggers, etc.
___Depression, irritability, sad mood, Low self esteem, loss of interest/pleasure.	____
___Suicide thoughts, intent, plans, or comments.	____
___Self-injurious behavior.	____
___Anxiety, excessive worries, separation fears.	____
___Difficulty identifying and expressing feelings.	____
___School/homework problems.	____
___School refusal/skips class.	____
___Attention issues in school, difficulty staying seated, waiting turn, blurting out answers, easily distracted, interrupts/intrudes.	_______________________________________
___Family problems (impacted by.)	_Describe: _______________________________ ____

Describe: For how long, how often/triggers, etc

___Defiance/arguing with parents. ____

___Defiance/arguing with teachers. ____

___Frequent temper tantrums. ____

___Drugs/alcohol or other chemical use. ____

___Losing control of anger and acting out aggressively. ____

___Cruel to others and/or bullying ____

___Cruel to animals. ____

___Stealing ____

___Running away ____

___Stealing or destruction of property ____

___Issues with food/eating Problems maintaining weight?______Intense fear of weight gain?_____Binge eating?_____Purging?____

____

___Not accepting responsibility for his/her own actions. ____

___Sleeping problems ____

___Social skills; making and keeping friends. ____

___Being bullied/taken advantage of by others. ____

___Abuse (physical, sexual or emotional) of child by other/s: ____

___Recent changes in behavior, health or personality. ____

How long have the checked issues been of concern? ________________________________

___Family history of depression. Child's: _____father ____mother _____grandparents

___Family history of anxiety. Child's: _____father ____mother _____grandparents

___Family history of substance abuse. Child's _____father ____mother _____grandparents

___Other mental health issues________________ _______father ____mother _____grandparents
_____________________ _________________ _________father ____mother _____grandparents

___Medical issues for child? Surgeries/accidents?____________________ _______________________

Medications?___________________________________Date of last physician check up?___________

___Birth story / developmental complications? ____

____

3. **Student's general weekly routine / homework/ activities / interests after school:**

Mon.____

Tues. ____

Wed. ____

Thurs. ____

Fri. ____

Weekend: ____
____
____
___ ____

Has child participated in counseling/ therapy services before? __Yes __No. If yes, please list dates/reasons: ____
____
____
____

Main reason for seeking therapy for child at this time: ______________________________________
____
____