PARENT/GUARDIAN ASSESSMENT Date:_____

Name of child: _____ Age: ___ Birth Date: _____

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

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

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

3. Please check your top priority concerns for your child below, and a provide 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.	_____
___Hearing voices-when there was no one there—speaking about them or telling them what to do or saying bad things to them.	_____
___Saying that they had intrusive/obsessive thoughts?	_____
___Repetitive behaviors or mental acts in response to intrusive/ obsessive thoughts:	_____
___Feeling the need to check on certain things over and over again, like whether a door was locked.	_____
___Worrying a lot about things touched being dirty or having germ?	_____
___Started more projects than usual, or did more Risky things than usual?	_____
___Slept less than usual, but still had lots of energy?	_____

Concerns (check those that apply.) **Describe: For how long, how often, triggers, etc.**

___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.) _____ _____

___Defiance/arguing with parents. _____

___Defiance/arguing with teachers. _____

___Frequent temper tantrums. _____

___Drugs/alcohol/vaping/cigarettes or other chemical use. _____

___Used any medicine without a doctor's Prescription? _____

___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 _____

Concerns (check those that apply.) **Describe: For how long, how often, triggers, etc.**

___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:

___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?_____ _____

Medication/s?_____Date of last physician check up?_____

___Birth story / developmental complications? _____
_____

Student's general weekly AFTER SCHOOL routine / homework/ activities / interests:

Mon._____
Tues. _____
Wed. _____
Thurs. _____
Fri. _____
Weekend: _____
_____
_____

Has child participated in counseling/ therapy services before? __Yes __No. If yes, please list
Date: _____ Reasons:_____
_____ _____

Main reason for seeking therapy for child at this time: _____
_____