Minor Client's Name_____ Date:_____

Parent(s) Name_____
(Please list the parent(s) name filling out this assessment on behalf of the minor child)

To help us better understand your child's needs and support you more effectively, we'd like you to complete a brief assessment. There are no right or wrong answers; please don't feel pressured to answer any question. We encourage you to be as open about your child as you feel comfortable. Your responses will help guide our conversations and ensure we focus on what matters most.

This assessment explores different areas of your child's life—physical, spiritual, relational, social, and academic health. Please complete this self-assessment, prior to your parent appointment, keeping answers brief.

During the initial appointment, your child's clinician will ask specific questions regarding your child's emotional health.

Instructions:

1. Take your time—most people complete the assessment in about 20 minutes.
2. Please answer each question based on how your child's been feeling or functioning in the past year.
3. If you're unsure about an answer, just do your best; you can always skip or discuss it with your child's clinician later.

If you have any questions or need help as you go, please contact our office.

Your Child's Information

Name: _____
First Middle Last

Date of Birth: _____ Age: _____

Primary Address:_____
Street City State Zip

Parent Information

Is the child your biological child? [ ] Yes [ ] No

If no, at what age was he/she fostered/adopted? _____

Describe ongoing contact with his/her biological parents? _____

Mother's Name: _____ Age: _____
First Last

Mother's Address: _____
Street City State Zip

Phone number(s): _____
(please list only ones we may contact) Home Cell Work

Father's Name: _____ Age: _____
First Last

Father's Address: _____
Street City State Zip

Phone number(s): _____
(please list only ones we may contact) Home Cell Work

Marital Status of Parents: [ ] Single [ ] Cohabitating [ ] Divorced [ ] Married [ ] Separated [ ] Widowed

Where does the child reside primarily? _____
I
f divorced, who has legal custody? _____

If divorced, what is the schedule for parenting time with each parent? _____

Physical Health

Does your child have any current or past medical condition(s) or surgical procedures (such as: diabetes, hypertension, thyroid issues, or chronic pain)? [ ] Yes [ ] No [ ] Unknown

If yes, please provide details and include timeframe(s):

If yes, describe how these have impacted his/her mental health:

Has your child suffered from any serious bodily injury? [ ] Yes [ ] No [ ] Unknown

If yes, please provide details and include timeframe(s):

If yes, describe the impact to his/her mental health:

Has your child ever experienced any physical accident or natural disaster that continues to impair his/her mental health?
[ ] Yes [ ] No [ ] Unknown

If yes, please provide details and include timeframe(s):

If yes, describe the impact to his/her mental health:

Describe any issues your child is currently having with sleep, appetite, energy levels, weight, lifestyle, etc:

Please list all current medications and supplements (vitamins/minerals) your child is currently taking (If you need more space, please indicate this to your clinician at the time of the initial appointment):

Medication/Supplement	Dosage	Prescribed By:	Why Prescribed?	Current Response? (Good/Fair/Poor)

List other current mental health treatment for your child:

Name	Location	When? *(month/year)*	For how long?

Doctor/NP/PA: _____

Clinician: _____

Psychiatric Hospitalization (any residential or day treatment programs, including any alcohol/drug treatment programs **in the last 2 years**):

Where?	When? *(month/year)*	Length of Stay	Type of Treatment	Diagnosis

Is your child sexually active? [ ] Yes [ ] No [ ] Unknown

Girls Only:
Age at first menstrual period: _____
Is menstruation regular? [ ] Yes [ ] No [ ] Unknown
Are there any difficulties related to menstrual periods? [ ] Yes [ ] No [ ] Unknown
If yes, please explain:

Spiritual Health

Does your child practice spirituality? [ ] Yes [ ] No [ ] Unknown

Does your child have a specific faith tradition he/she ascribes to? [ ] Yes [ ] No [ ] Unknown
If yes, what faith tradition?

Does your attend a local church, temple, synagogue, or mosque? [ ] Yes [ ] No
If yes, would you like to share where your child and/or family attend?

How often is your child attending?
[ ] 2-3 times per week
[ ] Weekly
[ ] 2 times per month
[ ] Never
[ ] Monthly
[ ] As needed
[ ] Holidays & Special Occasions

Is your child attending online or in-person?
[ ] Online [ ] In-Person [ ] Hybrid (online and in-person)

Does your child believe spirituality impacts his/her emotional health?
[ ] Yes [ ] No [ ] Unknown

Do you and/or your child wish for your child's spirituality to be integrated into his/her care?
[ ] Yes [ ] No [ ] Unknown

Any additional comments or experiences regarding your child's spirituality you would like to share:

Cultural/Heritage

What is your child's race? (choose one)
[ ] American Indian or Alaskan Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander
[ ] White or Caucasian
[ ] Other Please describe: _____

What is your child's ethnicity? (choose one)
[ ] Hispanic or Latino
[ ] Not Hispanic or Latino

Provide short answers for the next questions on behalf of your child:
Please share any information about your child's cultural background, ethnic heritage or family values:

Does your child's cultural background, ethnic heritage or family values affect his/her mental health?

What aspect of your child's culture background, ethnic heritage or family values is most important to his/her well-being?

Has your child ever experienced racism, discrimination, or marginalization that affects his/her mental health?

Is there anything about your child's language, customs, or traditions that your child would like respected during treatment?

Family Health

My child currently lives with (check all that apply):
[ ] Foster Parent(s)
[ ] Legal Guardian(s)
[ ] Adoptive Parent(s)
[ ] Biological Parent(s)
[ ] Maternal grandparent(s)
[ ] Paternal grandparent(s)
[ ] Other (please describe): _____

Immediate Family Members (please include: legal guardians, stepparents, siblings, stepsiblings and half-siblings)

Name	Age	Relationship to Child	How does child relate?

In your current family relationships, please answer the following true/false questions:

We talk to each other about things that matter to us.
[ ] True [ ] False

It feels risky to disagree in our family.
[ ] True [ ] False

It feels happy and content in our family.
[ ] True [ ] False

Our family members are kind and respectful to each other most of the time.
[ ] True [ ] False

We are good at working through difficult situations.
[ ] True [ ] False

When one of us is upset, we look after each other.
[ ] True [ ] False

There is or has been violence within our family.
[ ] True [ ] False

Our current family relationships impair my child's quality of life.
[ ] True [ ] False

Relational Health

Would like to share information regarding your child's sexual orientation or gender identification?

Briefly describe your child's most treasured relationship(s):

Social Health

Is your child satisfied with his/her social life? [ ] Yes [ ] No [ ] Unknown
If no, briefly describe:

My child struggles with *(check all that apply)*:

[ ] Conflict with peers/friends
[ ] Difficulty making/keeping friends
[ ] No/Limited support
[ ] Feeling withdrawn
[ ] Problems with social interaction
[ ] No relational issues

My child's friendships are *(check all that apply)*:

[ ] Too Old
[ ] Too Young
[ ] Too Many
[ ] Too Few
[ ] Spend too much time together
[ ] Engage in sexual activity
[ ] Other
[ ] Truant
[ ] Gang-related
[ ] Fringe *(friends that engage in risky behaviors together)*
[ ] Abuse Drug(s)/Alcohol
[ ] Violent and Destructive
[ ] Age and Developmentally Appropriate

If Other, please describe:_____

Does your child have a job? [ ] Yes [ ] No [ ] Unknown
If yes, please describe:

Describe your child's current relationship with you?
[ ] Positive [ ] Stressful [ ] Distant [ ] Oppositional [ ] Other? Please describe:_____

Who does your child trust to contact when he/she has problems?

Recreation

What are your child's hobbies and interests? (I.E. building models, fashion)

What does your child do in his/her leisure time?

What are your child's personal strengths, talents, and abilities? (I.E. loving, gifted singer, good with technology)

School

Where does your child attend school? _____

In what grade level is he/she? _____

What are his/her typical grades? _____

What are your child's academic strengths? _____

Any academic weaknesses? _____
Has there been a change in your child's performance at school? [ ] Yes [ ] No [ ] Unknown
If yes, please describe:

Has your child received IQ/Academic/Psychological Testing? [ ] Yes [ ] No [ ] Unknown
If yes, what were the results?

Has your child participated in any of the following?

Early Intervention Services (ages 0-3) or Birth – age 5	[ ] Yes [ ] No
Gifted, Accelerated, or Honors programs	[ ] Yes [ ] No
Head Start	[ ] Yes [ ] No
504 Plan or Individual Education Plan (IEP)	[ ] Yes [ ] No
Resource Room	[ ] Yes [ ] No

Has your child had problems with any of the following?

Absenteeism	[ ] Yes	[ ] No
Detention	[ ] Yes	[ ] No
Expulsion	[ ] Yes	[ ] No
Fights	[ ] Yes	[ ] No
School Refusal	[ ] Yes	[ ] No
Suspension	[ ] Yes	[ ] No
Truancy	[ ] Yes	[ ] No

Please add any other pertinent details about your child's academic needs:

Thank you for completing this assessment. We appreciate the time and effort it took. We look forward to seeing you and your child in our office.