

Appointment Date/Time: _____

**The Clark Institute for Infants, Children, and Adolescents
OUTPATIENT INITIAL ASSESSMENT/TREATMENT PLAN
CHILD/ADOLESCENT PART I**

IDENTIFICATION DATA:

Child/Adolescent Name: _____

Address: _____ City: _____ Zip: _____

Telephone No.: _____ Sex: M F Race: _____ Age: _____

Date of Birth: _____

Legal status: Minor Emancipated Minor Guardianship Ward

Parent or Guardian Names: _____

EMERGENCY CONTACT:

Name: _____ Telephone No.: _____

Address: _____

PRESENTING PROBLEM:

Who referred you/your child to the Clark Institute?

What is your reason for seeking treatment? _____

DAILY ACTIVITY INFORMATION:

List a few of your child's typical week day routines & activities: _____

List a few of your child's typical weekend routines & activities: _____

EDUCATION INFORMATION:

What is the highest level of school your child has completed? _____

What was/is the last/current school attended? _____

Has your child experienced any of the following in school? Learning Problems Discipline Problems

Social Problems Emotional Problems

Has there been any academic or psychological testing done at school or elsewhere? No Yes

If yes, when? _____

Results: _____

What's been your child's usual report card grades? _____

What's been your child's most recent grades? _____

SOCIAL/CULTURAL/SPIRITUAL INFORMATION:

What is your child's current religious or church involvement and preference? _____

What ethnic group does your child identify with? _____ To what extent? _____

Who does your child count on in times of trouble? _____

LEGAL HISTORY:

Please list any contacts your child has had with the courts: _____

Please list any contacts your child has had with the police: _____

EMPLOYMENT HISTORY (if applicable):

Please list any employment or regular chores of your child: _____

FAMILY HISTORY:

Father's Name: _____ Age: _____ Education: _____

Occupation: _____

Description of Father (not physical):

Year Deceased (if applicable): _____ Cause of death: _____

Description of relationship between father and child: _____

Mother's Name: _____ Age: _____ Education: _____

Occupation: _____

Description of Mother (not physical):

Year Deceased (if applicable): _____ Cause of death: _____

Description of relationship between mother and child: _____

Brothers and Sisters:

NAME	AGE	OCCUPATION	QUALITY OF RELATIONSHIP

Describe step-family information, if any:

NAME

AGE

RELATIONSHIP TO CHILD

Has anyone in your child's family had a psychiatric illness? No Yes

If yes, who and were they hospitalized? _____

Has anyone in your child's family attempted suicide? No Yes

If yes, who? _____

Has anyone in your child's family had a seizure disorder? No Yes

If yes, who? _____

Has anyone in your child's family had a problem with or treated for substance abuse problems? No Yes

If yes, who? _____

Has your child ever been physically, sexually or emotionally abused? No Yes

Has your child ever had previous psychiatric treatment, counseling or therapy? No Yes

Inpatient Outpatient

If yes, list names of previous mental health professionals: _____

Describe the results of past treatment and the reason for terminating treatment: _____

SUBSTANCE ABUSE HISTORY:

Please list any inpatient or outpatient treatment or educational programs for alcohol or drug use your child has received:

WHERE & WITH WHOM & WHY	TYPE OF TREATMENT	DATES	WAS IT HELPFUL?
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If your child uses drugs or alcohol, what is the current substance of preference? _____

Please list any incidents of overdoses, withdrawal or other adverse reaction(s) to drugs or alcohol, date(s) and description:

Check any word(s) that best describes your child's alcohol or drug use:

- EXPERIMENTAL RECREATIONAL ABUSIVE NONE
- ADDICTIVE DEPENDENT ALCOHOLIC MINIMAL

BIRTH AND DEVELOPMENTAL HISTORY:

Please complete as much of the following about your child as possible:

Is this child adopted? No Yes If yes, at what age? _____

Number of pregnancies of mother: _____ Which one was this child? _____

PREGNANCY: During pregnancy, did this child's mother:

Take any medications? No Yes

Have recurrent emotional problems? No Yes

Drink alcoholic beverages? No Yes Frequently smoke cigarettes? No Yes

About how much? _____ About how much? _____

Use any medications? No Yes Have a drug dependency? No Yes

Have hormone pills or injections? No Yes Other: _____

BIRTH: Length of pregnancy: _____

Was delivery: Difficult Easy Slow Quick

Were there any complications for delivery, i.e. Caesarean section or breech birth? No Yes

If yes, please explain: _____

Was there anything wrong with this baby at birth? No Yes

If yes, please explain (e.g. needed to be revived, have yellow jaundice, need oxygen): _____

FEEDING: Was this baby Breast fed Bottle fed Age weaned: _____

Was your child's development in the following areas early, normal or delayed?

	AGE IF KNOWN	EARLY	NORMAL	DELAYED
Sit alone _____				
Roll over _____				
Stand alone _____				
Walk by self _____				
Dress self (except for buttons and tying knots) _____				
Feed self with spoon or fork _____				
Speak first words (other than Mama/Dada) _____				
Speak first real sentences _____				
Become bladder trained (infrequent daytime accidents) _____				
	AGE IF KNOWN	EARLY	NORMAL	DELAYED
Become nighttime trained (rare accidents) _____				
Become bowel trained (no accidents) _____				
Help with household tasks _____				
Ride a tricycle _____				
Ride a bike _____				

Tie own shoes _____

We would like you to tell us about your child's current problem. Please circle the number which best describes your child on each particular problem.

	NOT A PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM
PROBLEMS WITH SLEEPING				
Trouble Sleeping	1	2	3	4
Nightmares	1	2	3	4
Sleep walking	1	2	3	4
Sleep Talking	1	2	3	4
SCHOOL PROBLEMS				
Has problems learning in school	1	2	3	4
Is afraid to go to school	1	2	3	4
Won't obey school rules	1	2	3	4
Often skips school	1	2	3	4
Has conflicts with teachers	1	2	3	4
Performs below his/her ability	1	2	3	4
RELATIONSHIP WITH OTHER CHILDREN				
Picks on other children	1	2	3	4
Has few or no friends	1	2	3	4
Is called weird by other children	1	2	3	4
Plays alone most of the time	1	2	3	4
Fights with other children	1	2	3	4
Has sex play with other children	1	2	3	4
Hangs around with bad crowd	1	2	3	4
Tried to boss others around	1	2	3	4
BEHAVIOR PROBLEMS				
Uses drugs	1	2	3	4
Runs away from home	1	2	3	4
Uses alcohol	1	2	3	4
Lies	1	2	3	4
Steals	1	2	3	4
Sets fires	1	2	3	4
Breaks things	1	2	3	4
Hurts animals	1	2	3	4
Assault	1	2	3	4
SOCIAL SKILLS				
Afraid of many things	1	2	3	4
Very shy	1	2	3	4
Poor loser	1	2	3	4
Demands too much attention	1	2	3	4
Withdraws from people	1	2	3	4
OTHER PROBLEMS WITH RELATIONSHIPS				
Talks back to adults	1	2	3	4
Disobeys parents	1	2	3	4
Can't be trusted	1	2	3	4
Isolates in room	1	2	3	4
Has a "chip" on his/her shoulder	1	2	3	4
Doesn't trust other people	1	2	3	4
EMOTIONAL PROBLEMS				
Is sad or unhappy most of the times	1	2	3	4
Cries a lot	1	2	3	4
	NOT A PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM
Has temper tantrums	1	2	3	4
Mood changes quickly	1	2	3	4
Has lost interest in things	1	2	3	4
Worries a great deal	1	2	3	4

Has difficulty making decisions	1	2	3	4
Has difficulty concentrating	1	2	3	4
OTHER				
Has threatened or attempted to harm self	1	2	3	4
Acts younger than real age	1	2	3	4
Wants things to be perfect	1	2	3	4
Can't sit still	1	2	3	4
Acts without thinking	1	2	3	4
Says or does strange things	1	2	3	4
Daydreams a lot	1	2	3	4
Doesn't finish things	1	2	3	4
Stutters	1	2	3	4
Is easily distracted	1	2	3	4
Bites nails	1	2	3	4
Doesn't speak well	1	2	3	4
Not fully bladder trained	1	2	3	4
Not fully bowel trained	1	2	3	4
Tired most of the time	1	2	3	4
Has aches and pains	1	2	3	4
Clumsy and accident prone	1	2	3	4
Fakes being sick	1	2	3	4
Chronically ill	1	2	3	4

Completed by: _____ Date: _____
(Please sign your name)

Thank you for your help in providing this information.

CLINICIAN ONLY BELOW THIS LINE:

My signature indicates my review of this information and as appropriate, any abuse and lethality issues with this child/adolescent.

Clinician signature: _____ Date: _____