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

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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?

If your child uses drugs or alcohol, what is the current substance of preference? ______________________________

Please list any incidents of overdoes, 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

❑ ADDICITVE ❑ DEPENDENT ❑ ALCOHOLIC ❑ MINIMAL

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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

About how much? ____________________

Frequently smoke cigarettes? ❑ No ❑ Yes

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: _____________

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