

**Portland Dialectical Behavior Therapy Program, PC
Teen/Family Additional Assessment**

Client Name: _____ **Date:** _____
Name of person filling out form: _____ **Relation to client:** _____

General information:

Please check the reasons you are bringing your child in for treatment

<input type="checkbox"/>	Defiance (loses temper easily, argumentative, does not comply with rules)
<input type="checkbox"/>	Conduct problems (runs away, physical aggression, bullies, truancy, stealing)
<input type="checkbox"/>	Attention problems/hyperactivity
<input type="checkbox"/>	Social problems (fear of social situations, socially awkward, difficulty making and keeping friends)
<input type="checkbox"/>	Anxiety (generally anxious, excessive worry, panic attacks)
<input type="checkbox"/>	Depression (sadness, social withdrawal, irritability)
<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	Cutting or other self-harm behavior
<input type="checkbox"/>	Suicidal ideation or suicide attempts
<input type="checkbox"/>	Eating disordered behavior (bingeing, purging, restricting, excessive exercise, laxative abuse, body image problems)
<input type="checkbox"/>	Sexual promiscuity, high-risk sexual behavior
<input type="checkbox"/>	Substance abuse
<input type="checkbox"/>	Legal problems
<input type="checkbox"/>	School problems
<input type="checkbox"/>	Other:

How have you tried to manage the problem or make it better?

<input type="checkbox"/>	Therapy	<input type="checkbox"/>	Discipline	<input type="checkbox"/>	School-teacher communication
<input type="checkbox"/>	Programs	<input type="checkbox"/>	Monitoring	<input type="checkbox"/>	Incentives

Are there any current family stressors that seem relevant to your child's difficulties?

What problems does your child currently have at home?

<input type="checkbox"/>	Doesn't do chores	<input type="checkbox"/>	Fights with siblings
<input type="checkbox"/>	Sneaks out	<input type="checkbox"/>	Runs away
<input type="checkbox"/>	Poor communication	<input type="checkbox"/>	Doesn't comply with limits and consequences

School information:

School Name			
Grade			
School Counselor	Name:	Phone Number:	

What problems does your child currently have in school?

<input type="checkbox"/>	Attendance problems	<input type="checkbox"/>	Individualized education plan
<input type="checkbox"/>	Poor grades	<input type="checkbox"/>	Held back
<input type="checkbox"/>	Behavioral problems Details:	<input type="checkbox"/>	Social problems Details:
<input type="checkbox"/>	Expelled When: Why:	<input type="checkbox"/>	Suspended When: Why:

Family information:

Relationship	Age	Occupation	Anything we should know about the relationship?
Biological mother			
Biological father			
Stepmother <input type="checkbox"/> NA			
Stepfather <input type="checkbox"/> NA			
Adopted mother <input type="checkbox"/> NA			
Adopted father <input type="checkbox"/> NA			

Is your child from a divorced home?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Age at time of divorce?	
How did child respond to the divorce?	

Is your child adopted?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Age at time of adoption	
Country of origin	
Other notable circumstances	

Who currently lives in your home?

Name	Age	Relationship	Anything we should know about the relationship?

Is there a family history of any of the following?

Aggression, oppositional behavior	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Attention, hyperactivity, impulsivity	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Psychosis, schizophrenia	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Mood problems, depression	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Anxiety problems, excessive worry	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Substance abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Legal problems	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Suicidalilty, self-harm	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:

Developmental history:

Complications during pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Substance use during pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes, details:
Problems with child's development (Circle those that apply) <input type="checkbox"/> NA	<input type="checkbox"/> Motor development (walking, coordination, balance) <input type="checkbox"/> Speech development (stuttering, speaking) <input type="checkbox"/> Sensory development (vision, hearing, reactions to noise) <input type="checkbox"/> Cognitive development (unusual thoughts, odd ideas/fantasies) <input type="checkbox"/> Academic development (learning problems, ADHD) Details:
Significant medical problems during childhood	Injuries <input type="checkbox"/> No <input type="checkbox"/> Yes, details: Age: Duration: Short/long-term consequences of problem: Short/long-term consequences of treatment: Illnesses <input type="checkbox"/> No <input type="checkbox"/> Yes, details: Age: Duration: Short/long-term consequences of problem: Short/long-term consequences of treatment: Hospitalizations <input type="checkbox"/> No <input type="checkbox"/> Yes, details Age: Duration:
Traumatic events <input type="checkbox"/> NA	<input type="checkbox"/> Sexual abuse <input type="checkbox"/> Physical abuse <input type="checkbox"/> Emotional abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Other trauma: _____ Details:
Between 0-3 what were the childcare arrangements?	
List a few of your child's strengths and interests	

Treatment history (fill out one row for each treatment, focusing on the last two years):

Treatment type	Time treatment began and ended	Person/agency name and comments
<input type="checkbox"/> Outpatient therapy <input type="checkbox"/> Psychiatric ED/hospitalizations <input type="checkbox"/> Psychiatric medication services <input type="checkbox"/> Residential services		
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