

Teen/Family Additional Assessment

Client name: _____ Age: _____ Gender: _____

Name of person filling out form: _____ Relation to client: _____

General Information

1. Please explain why you are bringing your child in for treatment?
 Defiance (loses temper easily, argumentative)
 Conduct Problems (runs away, physical aggression, bullies, truancy, stealing)
 Attention Problems/Hyperactivity
 Social Problems (fear of social situations, socially awkward, difficulty making and keeping friends)
 Anxiety (generally anxious, excessive worry, panic attacks)
 Depression (sadness, social withdrawal, irritability)
 Difficulty Sleeping
 Cutting or other Self-harm Behavior
 Suicidal Ideation or Suicide Attempts
 Eating Disordered Behavior (bingeing, purging, restricting, excessive exercise, laxative abuse, body image problems)
 Sexual Promiscuity, High-risk Sexual Behavior
 Substance Abuse
 Legal Problems
 School problems
 Other _____

2. How have you tried to manage the problem? What type of things have you done to make it better (e.g., therapy, discipline, increasing school-parent communication/monitoring, incentives)?

3. Any current family stressors that seem relevant to your child's difficulties? If yes, please explain.

4. Does your child currently have a prescribing physician for psychiatric medication?
Name: _____ Contact Number: _____

If no, are you interested in meeting with a DBT prescriber? Yes No Unsure
5. What problems does your child currently have at home? (e.g., doesn't do chores, fights with sibs, sneaks out, runs away, poor communication, doesn't comply with limits and

consequences)?

School Information

6. School Name: _____ Grade: _____
Number: _____ School Counselor: _____

7. Has your child ever been suspended, expelled or held back? (explain which, when and why):

8. What problems does your child currently have in school (e.g., attendance, grades, behavioral problems, individual education plan)?

9. How does your child do socially?

10. Please list a few of your child's strengths and interests?

Previous Treatment

11. Has your child seen a previous therapist for a significant period of time?

a. Therapist name: _____ Contact Number: _____

Reason: _____

Please provide details (e.g., where, when, approximate length of time, outcome)

b. Therapist name: _____ Contact Number: _____

Reason: _____

Please provide details (e.g., where, when, approximate length of time, outcome)

12. Has your child ever been hospitalized or placed in a residential treatment center due to alcohol/drug or mental/behavioral health problems? If yes, please provide information regarding:

c. Name of Facility: _____ Contact Number: _____

Reason: _____

When, where, approx. length of time, outcome?

d. Name of Facility: _____ Contact Number: _____

Reason: _____

When, where, approx. length of time, outcome?

Family Information

13. Information about parents:

a. Biological Father: _____ Number: _____

Present Age ____ Occupation _____

Anything we should know about the relationship?

b. Biological Mother: _____ Number: _____

Present Age ____ Occupation _____

Anything we should know about the relationship?

c. Stepmother: _____ Number: _____

Present Age ____ Occupation _____

Anything we should know about the relationship?

d. Stepfather: _____ Number: _____

Present Age ____ Occupation _____

Anything we should know about the relationship?

14. If your child is from a divorced home how old was he/she when the divorce occurred? How did he/she respond to the divorce?

15. Is your child adopted? ___ Y ___ N

If yes, please provide details (e.g., age at time of adoption, country of origin, other notable circumstances)

16. Between ages 0-3 what were the childcare arrangements for your child?

17. Who currently lives in your home? Name, age and relationship status (mother, step-father, full, step, or half-siblings, etc.)

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

Developmental History

18. Were there complications during pregnancy or delivery? ___ Y ___ N If yes, please explain:

19. Were substances used during pregnancy? ___ Y ___ N If yes, please explain:

20. Were there problems with your child's development? Including his/her...

- ___ Motor Development (walking, coordination, balance)
- ___ Speech Development (stuttering, speaking)
- ___ Sensory Development (vision, hearing, reaction to noises)
- ___ Cognitive Development (unusual thoughts, odd ideas/fantasies)
- ___ Academic Development (learning problems, ADHD)

If yes, please explain:

21. Any significant injuries, illnesses, hospitalizations or medical problems as a child? If yes, please provide details regarding age, duration, short and long-term consequences of the problem, treatment.

22. Are there any particularly traumatic or troubling events which have happened in your child's life which you think we should know about in order to understand your child better? If yes, please provide a brief explanation:

23. Is there a family history of any of the following?

- | | |
|--|--------------------|
| <input type="checkbox"/> Aggression, Oppositional Behavior | If yes, who? _____ |
| <input type="checkbox"/> Attention, Hyperactivity, Impulsiveness | If yes, who? _____ |
| <input type="checkbox"/> Psychosis, Schizophrenia | If yes, who? _____ |
| <input type="checkbox"/> Mood Problems, Depression | If yes, who? _____ |
| <input type="checkbox"/> Anxiety Problems, Excessive Worrying | If yes, who? _____ |
| <input type="checkbox"/> Substance Abuse | If yes, who? _____ |
| <input type="checkbox"/> Legal Problems | If yes, who? _____ |
| <input type="checkbox"/> Suicidality, Self-harm | If yes, who? _____ |