

# The Center for the Advancement of Human Potential

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**Initial Adolescent Assessment Date** \_\_\_\_\_

**Client's Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Sex:** M F

**School** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Handedness:** R L Mixed

**If no longer in school, highest grade or degree completed** \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_

**Your Name** \_\_\_\_\_ **Relationship to Child** \_\_\_\_\_

**Parents or Guardians** \_\_\_\_\_

**What is your major concern that led you and this client to seek our services?** \_\_\_\_\_

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**What other concerns do you have?** \_\_\_\_\_

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**Has the adolescent previously been assessed or received counseling (including school counseling) Yes** \_\_\_\_\_ **No** \_\_\_\_\_ If yes, please describe when, by whom, and with what tests.

Please bring any records or results with you to your appointment. \_\_\_\_\_

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**Does he/she have a psychiatrist? Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Name** \_\_\_\_\_

**Does he/she have a counselor? Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Name** \_\_\_\_\_

**MEDICAL HISTORY**

**Primary Care Doctor** \_\_\_\_\_

**Date of last visit?** \_\_\_\_\_

**Address** \_\_\_\_\_

**Would you like us to inform the doctor of the therapy received here? Yes \_\_\_ No \_\_\_\_\_**

**Height \_\_\_\_\_ Weight \_\_\_\_\_ Recent growth, weight gain or loss? \_\_\_\_\_**

**What medical or physical problems has your teen had?**

**Please check all that apply, indicating the age, and providing further explanation below:**

Visual problems \_\_\_\_\_

High fevers \_\_\_\_\_

Ear infections \_\_\_\_\_

Drug overdose/poisoning \_\_\_\_\_

Frequent colds \_\_\_\_\_

Headaches/migraines \_\_\_\_\_

Strept infections \_\_\_\_\_

Serious accidents \_\_\_\_\_

Sinus problems \_\_\_\_\_

Seizures \_\_\_\_\_

Allergy symptoms \_\_\_\_\_

Hypoglycemia \_\_\_\_\_

Hearing/speech disorders \_\_\_\_\_

Gastrointestinal problems \_\_\_\_\_

Head injury/concussion/whiplash \_\_\_\_\_

Skin problems \_\_\_\_\_

Other: \_\_\_\_\_

**Surgeries?** \_\_\_\_\_

**Females: Last Menstrual Period \_\_\_\_\_ Age Menses started \_\_\_\_\_ Menstrual problems? \_\_\_\_\_**

**Is he/she currently being treated for anything? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain.**

**Does he/she have any environmental allergies or food or medication sensitivities?**

**Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please indicate what testing has been performed and what treatment is used.**

**Please list all medications, including over the counter drugs, prescriptions, vitamins, herbs, or remedies that your teen is taking. Please include dosages, duration of use, how it affects your child and who prescribes it.** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Has this adolescent ever taken any medication for attention, behavior, or mood problems in the past? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list each below including dates of use, dosage, what taken for, who prescribed it and your child's response. \_\_\_\_\_

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\_\_\_\_\_ Please list all other current and previous treatments or therapies used indicating dates and results or effectiveness. \_\_\_\_\_

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Are immunizations up to date? Yes \_\_\_ No \_\_\_

Is this teen using any alcohol or other recreational drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what is his/her reaction to alcohol or other depressants? \_\_\_\_\_

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Does he/she use tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much per day? \_\_\_\_\_

Does anyone in the home smoke? \_\_\_\_\_

### **DEVELOPMENTAL HISTORY**

Was this teen adopted? Yes \_\_\_\_\_ No \_\_\_\_\_ At what age, if yes? \_\_\_\_\_

Were there any problems or unusual circumstances during the pregnancy or delivery?

Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_ Please explain. \_\_\_\_\_

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Were there any developmental delays or problems in learning to crawl, walk, use fine motor skills, or talk? Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_ Please explain. \_\_\_\_\_

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**Were there any problems during the first two years with feeding, eating, or sleeping?**

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Don't know** \_\_\_\_\_ **Please explain.** \_\_\_\_\_

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**SLEEP HABITS**

**Please describe your teen's sleep habits including how long it takes to fall asleep, how many times he/she wakes during the night, and if he/she goes to sleep and wakes on a regular schedule?** \_\_\_\_\_

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**Please check any of the following sleep problems your teen has now or has experienced in the past, and explain below.**

- |                                        |                                 |
|----------------------------------------|---------------------------------|
| _____ Difficulty waking in the morning | _____ Difficulty falling asleep |
| _____ Not rested after sleep           | _____ Physically restless sleep |
| _____ Frequent waking during the night | _____ Nightmares/ bad dreams    |
| _____ Sleeping too much                | _____ Teeth grinding            |
| _____ Sleep apnea (stops breathing)    | _____ Restless legs             |
| _____ Snoring                          |                                 |
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**DAILY ACTIVITY**

**Please describe your adolescent's schedule on a typical day.** \_\_\_\_\_

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**What types of exercise does he/she enjoy, and for how many hours per week?** \_\_\_\_\_

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How many hours per day does he/she watch television? \_\_\_\_\_

How many hours per day does he/she use the computer or play video games? \_\_\_\_\_

What are his/her favorite activities or hobbies? \_\_\_\_\_

How well does your teen handle personal hygiene? \_\_\_\_\_

## **NUTRITION**

Please describe your teen's diet on a typical day:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Appetite? Good \_\_\_ Fair \_\_\_ Poor \_\_\_ Sporadic \_\_\_ Affected by medication \_\_\_\_\_

Does this teen have any problems with food cravings, dieting, or weight maintenance?

Yes \_\_\_ No \_\_\_ If yes, please explain, \_\_\_\_\_

Favorite foods: \_\_\_\_\_

How many sodas, sport drinks or sugared juice drinks does he/she drink in a day? \_\_\_\_\_

How many caffeinated beverages does he/she have in a typical day? \_\_\_\_\_

What is your teen's reaction to caffeine or other stimulants, such as cold medication? \_\_\_\_\_

Does your teen use any sugar substitutes or eat/drink diet or sugar substituted products?

Yes \_\_\_ No \_\_\_ If yes, which substitutes? \_\_\_\_\_

Food aversions or sensitivities: \_\_\_\_\_

Have you tried any dietary restrictions? \_\_\_\_\_  
\_\_\_\_\_

**FAMILY/SOCIAL DEVELOPMENT**

What is the teen's current living situation? \_\_\_\_\_  
\_\_\_\_\_

Has he/she experienced disruptions or upsets involving the family, including births, deaths, illnesses, marital changes, changes in family structure or living arrangements, parental or household member conflicts, financial problems, drug or alcohol use, changes in school situations, or any other significant events or issues? Please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you aware of any abuse or trauma in this adolescent's background? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please indicate if your teen has or has had difficulty in any of the following areas and explain below.**

- |                                  |                          |                                     |
|----------------------------------|--------------------------|-------------------------------------|
| _____ Inattention                | _____ Distractibility    | _____ Anger tantrums                |
| _____ Impulsivity                | _____ Depression         | _____ Compulsive behavior           |
| _____ Irritability               | _____ Agitation          | _____ Muscle/ Verbal Tics           |
| _____ Anxiety                    | _____ Fears              | _____ Lack of remorse               |
| _____ Obsessive thoughts/worries | _____ Phobias            | _____ Inability to read social cues |
| _____ Panic attacks              | _____ Poor concentration | _____ Poor self-esteem              |
| _____ Daydreaming                | _____ Poor insight       | _____ Poor peer relations           |
|                                  | _____ Stimulus seeking   | _____ Poor sibling relations        |
- \_\_\_\_\_  
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**What conditions or triggers seem to worsen his/her behavior?** \_\_\_\_\_

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**What helps to calm, or regulate behavior for this teen?** \_\_\_\_\_

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**Has he/she ever become violent or destructive? Has he/she ever hurt an animal or person intentionally or threatened to harm or kill someone?** \_\_\_\_\_

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**What problems, if any, has your teen had with authority, with getting into trouble, unlawful behavior that could cause legal problems?** \_\_\_\_\_

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**Are you aware of any suicidal thoughts or actions? If yes, please describe.** \_\_\_\_\_

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**What are your teen's strengths** \_\_\_\_\_

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### **FAMILY MEDICAL HISTORY**

**Please circle any applicable conditions or diseases and indicate which family member is affected.**

ADD/ADHD

Autism/ Aspergers

Depression

Allergies

Bipolar Disorder

Developmental Disorders

Alcoholism

Bleeding Problems

Diabetes

Anemia

Cancer

Eating Disorders

Arthritis

Colon Disease

Epilepsy/ Seizures

Asthma

Dementia

Gastrointestinal Disorders

Headaches/ Migraines  
Heart Disease  
Hypertension  
Kidney Disease

Learning Disabilities  
Mental Disorders  
Skin Disease  
Stroke

Thyroid Disease  
Tics/ Tremor  
Ulcer

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## **SCHOOL HISTORY**

**Please indicate if your teen has had any of the following problems and at what age.**

	<u>Preschool</u>	<u>Elementary</u>	<u>Middle</u>	<u>High School</u>
<b><u>Reading Difficulties</u></b>	_____	_____	_____	_____
- <b>dyslexia</b> (difficulty learning to read, blend sounds, read smoothly)	_____	_____	_____	_____
- <b>poor tracking</b> (loosing place in line, missing words)	_____	_____	_____	_____
- <b>poor comprehension</b>	_____	_____	_____	_____
<b><u>Math Difficulties</u></b>	_____	_____	_____	_____
- <b>poor arithmetic calculations</b>	_____	_____	_____	_____
- <b>poor sequencing, ordering</b>	_____	_____	_____	_____
- <b>poor grasp of concepts</b>	_____	_____	_____	_____
<b><u>Writing Difficulties</u></b>	_____	_____	_____	_____
- <b>poor handwriting</b>	_____	_____	_____	_____
- <b>poor organization</b>	_____	_____	_____	_____
- <b>poor mechanics</b>	_____	_____	_____	_____
<b><u>Behavior Problems</u></b>	_____	_____	_____	_____
- <b>interference with learning</b>	_____	_____	_____	_____
- <b>peer or social problems</b>	_____	_____	_____	_____
- <b>problems in group activities</b>	_____	_____	_____	_____
- <b>disliked or avoided at school</b>	_____	_____	_____	_____



**Thank you for all your time and effort in completing this lengthy form. We really do appreciate receiving the information we need to understand how each individual client is challenged and gifted. Please bring any other records, test results, school results, or pertinent information to your appointment. We look forward to working with you and your child.**