

# The Center for the Advancement of Human Potential

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## INITIAL CHILD ASSESSMENT

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

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

Parent or Guardian (to whom we can release information) \_\_\_\_\_

What is your major concern that led you to seek help for this child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What other concerns do you have about this child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the child 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. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have a psychiatrist? Yes \_\_\_\_\_ No \_\_\_\_\_ Name \_\_\_\_\_

## MEDICAL HISTORY

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

Date of last visit? \_\_\_\_\_ Address \_\_\_\_\_

Would you like us to inform the doctor of the therapy your child receives here? Yes \_\_\_\_\_ No \_\_\_\_\_

**What medical or physical problems has your child 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 _____             |

**Surgeries?**

**Is your child currently being treated for anything? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain.**

**Does your child 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 child is taking. Please include dosages, duration of use, how it affects your child and who prescribes it.**

Has your child 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 your child's immunizations up to date? Yes \_\_\_\_\_ No \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

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

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

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

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. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

Handedness: R L Mixed

## **SLEEP HABITS**

Please describe your child'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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- \_\_\_\_\_ Difficulty waking in the morning
- \_\_\_\_\_ Not rested after sleep
- \_\_\_\_\_ Frequent waking during the night
- \_\_\_\_\_ Sleeping too much
- \_\_\_\_\_ Sleep apnea (stops breathing)
- \_\_\_\_\_ Snoring

- \_\_\_\_\_ Difficulty falling asleep
- \_\_\_\_\_ Physically restless sleep
- \_\_\_\_\_ Nightmares/ bad dreams
- \_\_\_\_\_ Teeth grinding
- \_\_\_\_\_ Restless legs

## **DAILY ACTIVITY**

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

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

How many hours per day does your child 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 child handle personal hygiene? \_\_\_\_\_  
\_\_\_\_\_

**NUTRITION**

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

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

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

Does your child 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 this child drink in a day? \_\_\_\_\_

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

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

\_\_\_\_\_

Does your child 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? \_\_\_\_\_

\_\_\_\_\_

Is this child using any alcohol or other recreational drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what is

his/her reaction to alcohol or other depressants? \_\_\_\_\_

\_\_\_\_\_

Does this child use tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much per day? \_\_\_\_\_

**FAMILY/SOCIAL DEVELOPMENT**

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

\_\_\_\_\_

Has your child 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 child's background? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please indicate if your child has difficulty in any of the following areas and describe 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        |

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What conditions or triggers seem to worsen this child's behavior?** \_\_\_\_\_

\_\_\_\_\_

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

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

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

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

**FAMILY MEDICAL HISTORY**

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

ADD/ADHD

Colon Disease

Hypertension

Allergies

Dementia

Kidney Disease

Alcoholism

Depression

Learning Disabilities

Anemia

Developmental Disorders

Mental Disorders

Arthritis

Diabetes

Skin Disease

Asthma

Eating Disorders

Stroke

Autism/ Aspergers

Epilepsy/ Seizures

Thyroid Disease

Bipolar Disorder

Gastrointestinal Disorders

Tics/ Tremor

Bleeding Problems

Headaches/ Migraines

Ulcer

Cancer

Heart Disease

## SCHOOL HISTORY

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

Preschool      Elementary      Middle      High School

### Reading Difficulties

**-dyslexia** (difficulty learning to

read, blend sounds, read smoothly)

**-poor tracking** (loosing place in line,  
missing words)

**-poor comprehension**

### Math Difficulties

**-poor arithmetic calculations**

**-poor sequencing, ordering**

**-poor grasp of concepts**

### Writing Difficulties

**-poor handwriting**

**-poor organization**

**-poor mechanics**

### Behavior Problems

**-interference with learning**

**-peer or social problems**

**-problems in group activities**

**-disliked or avoided at school**

**Poor visio-spatial skills** (drawing, copying)

**Poor spelling**

**Poor sense of direction**

**Poor balance or coordination**



