Child Psychosocial Inventory

Parents, please complete the following information regarding your child prior to your first appointment and bring it with you to the session. Completing this form in advance will help the assessment process go more quickly. If you are unsure of an answer or feel that a question does not apply, you may leave it blank. All information will be kept confidential.

Date: ______________________________ Form completed by: ___________________________

Presenting Problem:

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What are the main concerns that bring you to therapy?

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How long has this been a concern?

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What do you hope to get from therapy and what are your goals for therapy?

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Have you noticed any changes or problems with your child's sleep, appetite, or hygiene?

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Is there any history of trauma or upsetting life events (such as abuse, life threatening accidents or medical concerns, family conflict, bullying, divorce, death or loss of loved ones, or natural disasters)? If yes, please describe.

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Has your child ever had psychotherapy or counseling before? If yes, please describe.

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Has your child been given a previous psychological diagnosis? If yes, please describe

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Is your child currently taking any medications for emotional or behavioral reasons? If yes, please list name of medication, dosage, and reason prescribed.

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Has your child taken any other medications in the past for emotional or behavioral reasons? If yes, please list name of medication, dosage, and reason prescribed.

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Has your child ever been hospitalized for emotional or behavioral concerns? If yes, please describe reason and provide name of hospital.

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Has your child ever made suicidal statements, made suicide attempts, or self-harmed (including cutting)? If yes, please describe.

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Do you have concerns that you child may be using drugs or alcohol? If yes, please describe.

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Medical History:

Primary Care Doctor or Pediatrician:____
Date of last physical exam: ____

Please describe any past and present medical concerns or serious illnesses:

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Please list any current medications and reason for taking:

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Has your child ever been hospitalized for medical reasons or had surgery? If yes, please describe.

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Does your child have any problems with vision, hearing, or dental health? If yes, please describe.

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Are you aware of any sensory processing issues that your child has? If yes, please describe.

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History:

What is your child's temperament and personality like?

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Does your child like school?

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How are your child's social relationships? Does your child have and make friends easily?

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Does your child have any current stressors within the family?

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Family Information:

Please list family members that live in the home with child, including names and ages:

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____
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Other immediate family members that live outside of the home (i.e., parents or siblings):

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____
____

Primary caregivers' relationship status: Married____ Single____ Engaged____ Divorced____

Co-habituating ____Separated____ Divorced____ Widowed ____

Is there any family history of mental illness (including extended family)? If yes, please describe.

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What do you consider to be your family strengths?

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School Information:

Current School: ____
Grade: ________________________________

Does your child have an IEP or other special services at school? If yes, please describe.

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Has your child been diagnosed with a learning disorder or other educational impairment? If yes, please describe.

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Do you have any concerns about your child's behavior or academics at school? If yes, please describe.

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Does your child participate in an afterschool program or other extracurricular activities? If yes, please describe.

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Additional Information:

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What are some of the strengths and positive qualities of your child?

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Is there any other information that I should know regarding your child or family?

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