Child and Family Information Assessment Form

Name: _____ Date: _____
ID #: _____ Gender: M F Age: _____
Birth date: _____ Telephone number: _____
Address: _____
City: _____ State: _____ Zip code: _____
Information recorded by: _____
Information supplied by (name and relationship to the client): _____
_____
Presenting problem(s):
_____
_____
_____
_____
_____

Child's Demographics

Child's full legal name: _____
Preferred nickname: _____ Ht: _____ Wt: _____
Hair color: _____ Eye color: _____ Birthplace: _____
Ethnic identification: _____ Year in school _____
Child's current residence: ___ With biological parents ____ Other: _____
If "other," please explain: _____
_____

Parents' Demographics

Father's name: _____ Birth date: _____
Biological parent? ___ No ____ Yes
Address: _____
City: _____ State: _____ Zip code: _____
Employer: _____
Address: _____ Telephone number: _____
City: _____ State: _____ Zip code: _____
Occupation: _____ Shift: _____

Mother's name: _____ Birth date: _____
Biological parent? ___ No ___ Yes
Address: _____
City: _____ State: _____ Zip code: _____
Employer: _____
Address: _____ Telephone number: _____
City: _____ State: _____ Zip code: _____
Occupation: _____ Shift: _____

Alternate Contacts

Emergency contact: _____
Telephone number: _____ Relationship: _____

Custody and Legal School District of Residence

Who has legal custody of the child? _____
___ Temporary ___ Permanent Telephone number: _____
Address: _____ County: _____
City: _____ State: _____ Zip code: _____

If the Department of Human Service (Welfare) has custody (i.e., foster care placement), indicate the address of the parents at the time that the department took custody:

Parent's name: _____
Address: _____ County: _____
City: _____ State: _____ Zip code: _____
School district: _____

Parents' Marital History/Current History

Mother (Father)
Married: _____ To: _____
Separated: _____ From: _____
Divorced: _____ From: _____
Remarried: _____ To: _____
Other: _____

Family and Home Information

All persons currently living in the household:

Name	Birth date	Sex	Education level	Relationship

Natural parents of siblings who do not live in the household:

Name	Birth date	Sex	Education level	Relationship

Has the child lived with both parents since birth? ____ No ____ Yes

If "no," list changes chronologically (include residential placements).

From: (Dates preferred, or child's ages).	To:	Child lived with:

If child is not living with both parents, please list reason:

____ Parents separated ____ Parents divorced ____ Parent deceased ____ Other

If "other," please explain: _____

_____

If the child has a parent not living with the child, are there visitations?

____ No How frequently: _____

____ Yes Reason: _____

If there are any other children living in the family:

A. Do any of them have physical or emotional problems? ____ No ____ Yes
   If "yes," please explain: _____
   _____

B. If "yes," have they received counseling or other forms of help? ____ No ____ Yes
   If "yes," please explain: _____
   _____

Is your house troubled by domestic violence? ____ No ____ Yes

If "yes," please explain: _____

_____

_____

Does any family member have an alcohol or drug problem? ____ No ____ Yes

If "yes," please explain: _____

_____

_____

Child's Developmental and Medical History

Were there any prenatal problems during pregnancy? ___ No ___ Yes

If "yes," please explain: _____

_____

_____

Were there any problems during delivery? ___ No ___ Yes

If "yes," please explain: _____

_____

Birth weight: _____ lbs _____ oz.

Infancy:

A. Were there any feeding problems? ___ No ___Yes

If "yes," please explain: _____

_____

B. Did your child sleep well? ___No ___Yes

If "no," please explain: _____

_____

C. At what age was your child toilet trained? _____

Were there any difficulties? _____

_____

Milestones

At what age did your child:

_____ Wean _____ Walk _____ Sit up alone _____ Talk

Were there any difficulties? _____

_____

Are there any problems with bedwetting/accidents? ___No ___Yes

_____ Night _____ Frequency

_____ Daytime accidents _____ Frequency

Please indicate age of child at the time of illness:

_____	Chickenpox	_____	Mumps
_____	Diphtheria	_____	German measles
_____	Red measles	_____	Poliomyelitis
_____	Rheumatic fever	_____	Scarlet fever
_____	Tuberculosis	_____	Whooping cough
_____	Pneumonia	_____	Other

If "other," please explain: _____

_____

Does or did your child ever have severe ear infections? ___No ___Yes
Does or did your child have allergies? ___No ___Yes
If "yes," to what does the child have allergies? _____

_____

How severe are the reactions? _____
Are there any special precautions that need to be taken? _____

_____

Does or did your child have lead poisoning? ___No ___Yes
If "yes," please explain: _____

_____

Please detail any of your child's hospitalizations:

Date	Age	Hospital	Reason	Length of stay

Please detail any medication history:

Date	Age	Drug	Reason	Physician

Family Medical History

Is there a history of any of the following in the family?
(Use "M" for mother's side; "F" for father's side.)

_____	TB	_____	Vision problems
_____	Birth defects	_____	Hearing problems
_____	Emotional problems	_____	Drugs
_____	Behavior problems	_____	Alcohol
_____	Mental retardation	_____	Diabetes
_____	Goiter (Thyroid)	_____	Convulsions/seizures
_____	Other		

If "other," please explain: _____

_____

Further comments: _____

_____

_____

_____

Agency Involvement/Service Treatment History

Please include (chronologically if possible) as complete a history as possible. Include agencies, physicians, counselors, institutions, therapists, etc.

Date	Age	Contact person	Services provided	Length of involvement

Has your child been court involved? ___No ___Yes

If "yes," please explain: _____

_____

Child's School History

School attendance:

	Date	Location	Problems (Y/N)	Reason for leaving
Preschool				
Kindergarten				
Grade 1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

If answered "yes," to problems at any academic level, please detail here. Please give any information about treatment (if any) provided by the school at the time of occurrence:

_____

_____

_____

_____

_____

Typical Day Descriptions

A. On a school day, how does the child awaken? (by himself, by you, etc.)

_____

B. How does your child prepare himself for the day? (Who selects clothing, etc.?)

_____

C. Does the child ready himself quickly or require continual reminding?

_____

D. Does the child eat breakfast? ____No ____Yes If so, who prepares it?

_____

E. Does the child watch the time and leave promptly or is frequent reminding necessary?

_____

F. Does the child come home for lunch? ____No ____Yes

If so, who prepares it? _____ Any problems? _____

Does the child watch the time and leave promptly or is frequent reminding necessary? ____No ____Yes

G. What does the child do after school?

_____

H. What occurs at dinnertime?

_____

1. Does the family eat together? ____No ____Yes
2. Is the child on time? ____No ____Yes
3. Are there any problems during dinner? ____No ____Yes
4. Does he/she participate in family conversations during meals? __No ___Yes

If you answered "no," to any or these questions, or "yes," to question 3., please explain: _____

_____

I. What occurs after dinner?

_____

J. What happens at bedtime?

_____

K. What does the child do on weekends?

Friday night: _____

Saturday: _____

Sunday: _____

L. Does your family have much "family time" together (shopping, movies, etc.)?

_____

M. What activity do you enjoy most with your child?

_____

N. Does you child spend time with friends?

How much time on a weekly basis? _____

How many friends does you child have? _____

How do you feel about your child's friends? _____

O. Does your child belong to any clubs, groups, or organizations?

If so, which ones: _____

_____

P. Does you child have any interests or hobbies?

_____

Q. Does you child get an allowance? ___No ___Yes

If so, is it earned or given? _____

How does the child manage the money? _____

R. Does your child have specific chores? ___No ___Yes

If so, what are they? _____

Does you child try to avoid doing chores? ___No ___Yes

What does he do to try to avoid them (refuse, argue, etc.)? _____

_____

S. What methods do you use to discipline your child? _____

_____

How often is it necessary? _____

Does it work? _____

Behavior Checklist

Check the behaviors listed below that apply to your child within the past 6 months.

___ Makes no sounds.

___ Makes sounds but says no words.

___ Says a few words (specify: _____).

___ Speaks well but was slow in developing speech.

___ Repeats words over and over.

___ Was speaking but is no longer.

___ Is clumsy and awkward.

___ Is often drowsy.

____ Displays stereotypic behaviors (for example: wave hands in front of face, stares blankly, etc.) If so, which ones: _____

____ Engages in self-destructive behaviors:

____ hair pulling ____ self-biting ____ self-pinching ____ head banging

____ other (please specify): _____

____ Has tantrums frequently.

____ Is hyperactive.

____ Seldom makes eye contact.

____ Demands too much attention.

____ Is often sluggish or slow moving.

____ Often has physical complaints (i.e., headaches, stomachaches, etc.).

____ Usually plays alone.

____ Disobedience, difficulty with disciplinary control.

____ Asks for help when it is not needed.

____ Gives up easily.

____ Does not interact appropriately with:

____ Parents ____ Siblings ____ Peers ____ Others

____ Physically abuses:

____ Parents ____ Siblings ____ Peers ____ Pets ____ Toys ____ Furniture

____ Cries, whines, or pouts frequently.

____ Unreasonable noise, yelling.

____ Does not play with toys.

____ Rarely obeys requests, commands, etc.

____ Talks back to parents or other authority figures.

____ Reacts poorly when losing a game.

____ Unreasonable fears (heights, animals, the dark, etc.) Please specify: _____

_____

____ Does not recognize danger.

____ Runs away frequently.

____ Does not observe curfew.

____ Will not play alone.

____ Problems at mealtimes (disruptive, selective about foods).

____ Has a sleeping problem.

____ Cannot feed self.

____ Cannot dress self.

____ Is not toilet trained.

____ Is toilet trained but: ____ wet pants. ____ soils pants. ____ wets bed.
____ Frequent lying.
____ Sets fires.
____ Steals.
____ Seems to have a hearing problem.
____ Seems to have a vision problem.
____ Other physical handicap (specify: _____).
____ Negative comments to:
____ Parents ____ Siblings ____ Peers ____ Others
____ Teasing of:
____ Parents ____ Siblings ____ Peers ____ Others
____ Complaining.
____ Wanders off.
____ Sadness.
____ Complaints from neighbors.
____ Police contact.
____ School contact.

Please describe other problems: _____

_____

_____

What behavior distresses you the most? _____

_____

_____

What do you think are your child's greatest strengths? _____

_____

_____

Please describe the changes you hope to see in your child as a result of our work:

_____

_____

_____

_____

_____

_____

_____

_____