Temanos Counseling Center · Ginna Maus, LCSW

Child Comprehensive Assessment

Client Name: **Date:** **Time:**

Clinician: **CPT Code:_____** **# Units** _____

IDENTIFYING INFORMATION:

CLIENT/FAMILY CONCERNS: *referred by – description of symptoms, behavior, feelings, thoughts, sleep, and appetite*

A. Reason for seeking services at this time? *(current condition,* See attached symptom checklist as well)

B. History of present illness?

C. What changes have you tried to make? What was the outcome?

D. What are your goals for therapy?

- What are your expectations of your child?
- What changes would you like to see in yourself?
- What changes would you like to see in your family?

MENTAL STATUS EXAM:

Grooming *Normal ( ) Disheveled ( ) Unusual ( )*
Hygiene *Normal ( ) Body Odor ( ) Bad Breath ( )*
Interpersonal: *Cooperative ( ) Oppositional ( ) Resistant ( ) Defensive ( ) Other ( )*
Speech: *Normal ( ) Pressured ( ) Dysarthric ( ) Slow ( ) Apraxic ( )*
Mood: *Normal ( ) Irritable ( ) Euphoric ( ) Anxious ( ) Elevated ( ) Depressed ( ) Angry ( )*
Affect: *Broad ( ) Restricted ( ) Labile ( ) Flat ( ) Blunted ( ) Inappropriate ( )*
Motor Activity*: Relaxed ( ) Restless ( ) Pacing ( ) Sedate ( )* Mannerisms ( ) *Other ( )*
Estimated IQ: *Above Average ( ) Average ( ) Below Average ( )*

Clinician signature*:* _____ **Date*:*** _____

Attention: *Normal ( ) Distractible ( ) Hypervigilant ( )*
Concentration: *Normal ( ) Brief ( ) Insight ( ) Good ( ) Fair ( ) Poor ( )*
Recent Memory *Normal ( ) Abnormal ( )*
Remote Memory *Normal ( ) Abnormal ( )*
Judgment *Good ( ) Fair ( ) Poor ( )*
Hallucination *None ( ) Auditory ( ) Visual ( ) Olfactory ( ) Gustatory ( )*
Thought Process *Normal ( ) Blocking ( ) Loose Associations ( ) Confabulation ( ) Suicidal Ideation ( ) Homicidal Ideation ( ) Delusions ( ) Depersonalization ( ) Grandiosity ( ) Flight of Ideas ( ) Ideas of Reference ( ) Other* _____

CLIENT/FAMILY HISTORY:

A. Birth and Developmental history – *milestones, childhood experiences*

B. Past Psychiatric History:

C. Medical History:

D. Current Medications:

D. Relationship with parents, siblings, extended family? *Place of birth, physical moves, parents living or date/cause of death, which parent/sibling closest to and why, parent/sibling most distant and why, parental discipline style and how child responds*

E. Separation, divorce, or custody history and/or ongoing issues?

F. What do this child like and dislike about school?

E. Have you ever been involved with CPS? YES NO
a. If yes, is your case currently open? YES NO
b. If your case is open, who is your caseworker?

F. Have you ever been involved with the Juvenile Justice Department? YES NO
a. If yes, is your case currently open? YES NO
b. If open, who is your caseworker?

Clinician signature: _____ **Date:** _____

FAMILY STRENGTHS:

A. Family activities and rituals: *ways family show they care*

B. Religious and/or cultural affiliations:

CHILD/YOUTH STRENGTHS: *if client can't say, ask them what their family/friends would say?*

A. What are your interests/inner strengths: *sports, art, personal qualities, what resources do they have that may be harnessed to help cope with their psychological problem*

B. What do you like to do with friends?

C. What do you like to do with your family?

CLIENT / OTHER FAMILY OF ORIGIN INFORMATION: *for client & family*

1. Alcohol and drug use/abuse?

2. Physical, sexual abuse?

4. Emotional abuse and/or neglect?

5. Grief and loss history?

6. Other traumas? *Car accidents, environmental trauma, etc.*

7. Dangerousness to self and others?

ADDITIONAL COMMENTS:

What does this client need?

What are this client's resources?

What are this client's barriers to treatment?

What is this client's readiness & motivation to participate in treatment?

Clinician signature: _____ **Date:** _____

DSM-IV DIAGNOSIS:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: GAF

MEDICAL NECESSITY CRITERIA:

___ SED for Children or SMI for Adults
___ Documentation that participant is presently at risk for an out-of-home placement. DOCUMENTATION:
___ Clinical deterioration that would lead to an out-of-home placement. DOCUMENTATION:
___ Further clinical deterioration which would interfere with the participant's ability to maintain current level of functioning (if this is used then a description of the participant's current level of functioning must also be documented). DOCUMENTATION:

TREATMENT RECOMMENDATIONS: *(level of care, intensity of treatment, expected duration of treatment and services)*
__ *Individual Psychotherapy ___ times per month.*
__ *Family Psychotherapy ___ times per month.*
__ *Other*

EXPECTED DURATION OF TREATMENT: __ 6 mos., __ 12 mos., __ other

RECOMMENDATIONS: (*level of care, intensity of treatment, expected duration of treatment and services*)

REFERRALS:

Clinician signature*:* _____ **Date*:*** _____