TRYSHA LM BODDEN, LMFT, LLC
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Phone (808) 294-5810 Fax (808) 441-7744

Child and Adolescent Initial Assessment Supplemental Information

Child's Name: _____ Age:_____

Who has custody of child?

Mother___Father___ Both___ Relative___ Other_____

Child's School History:

School Name: _____ Grade:_____

Teacher/Counselor/IEP coordinator: _____

Phone: _____

Review history of school functioning including strengths: (gifted or accelerated, learning problems, behavioral problems, multiple school placements, past educational testing, estimated level of achievement):

Is your child in Special Education? **Yes or No**

Current IEP **Yes or No**

Child's Classroom setting: (**please check which applies**)

Regular classroom___ Regular classroom with pull out to Resource room__

Special education classroom__ Inclusion in regular education__ Aide__

What school interventions have been used to address problems?

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None___ Special seating arrangement___ tutoring__ groups___ classroom aide__ Parents called___ Other:_____

Has child been suspended or expelled? If yes how many times and for what reasons?

Child Symptoms and Behaviors:

Presenting problems: Please state your concerns; specify nature of problem, duration, frequency and severity:

Please indicate which of the following symptoms/problems/complaints are affecting your child (circle all that apply):

Irritability panic attacks hyperactivity runs away mood swings

speech difficulties sexual behaviors little or no friends learning problems

fatigue/decrease in energy provokes others anger outbursts increased

loss of appetite cruelty towards animals separation anxiety

school avoidance quick tempered difficulty staying on task

poor social skills bullies others cries loss of interest in activities

frequent fighting steals worry/fear inattentive difficulty sleeping

self-harm behaviors distractibility isolates/withdrawals

academic decline defiant/disobedient sadness suicidal thoughts

nightmares weight change binging/purging hopelessness

wet/soils bed

Notes:

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Please describe any ***significant events*** in your family life that may have had an impact on your child's life (i.e. major moves, changes in school, divorce, loss of a loved one,

Describe any ***physical or mental illness*** that runs in the family including depression or suicide:

Describe any current or past history of ***substance abuse*** in the family:

Describe any ***developmental history*** that is significant (developmental delays, premature, colic, feeding issues, chronic illness, complications at birth:

Additional Information Pertinent to treatment:

_____

Signature of Parent/Guardian **Date**