PRE-EVALUATION FORM—CHILD

Name: _____ DOB: _____ Date: _____

Gender: ____ Age: _____ Grade: _____ School:_____ District:_____

Reason for appointment:

1. _____
2. _____
3. _____

Main goals:

1. _____
2. _____
3. _____

	Mother	Father
Circle one	Biological/Adoptive/Foster	Biological/Adoptive/Foster
Name and DOB		
Address (if different from child)		
Preferred phone contact		
Occupation		
Employer		
Education Level		
Marital status		

Custody Arrangement (if applicable):_____

SAFETY CONCERNS—If Yes, please explain:

Does your child have thoughts of hurting themselves or others? **YES** **NO**

If Yes, describe:

Does your child engage in any self-harm such as cutting or burning? **YES** **NO**

Does your child problems with hallucinations (hearing or seeing things)? **YES** **NO**

Does your child seem paranoid (like others are out to get them) or have bizarre behaviors? **YES** **NO**

Are you concerned that your child is being abused? **YES** **NO**

Are you concerned that your child is abusing drugs or alcohol? **YES** **NO**

Are you concerned that your child has an eating disorder? **YES** **NO**

Other family members (if shared custody list make up of both homes)

Name	age	Relationship to child? (Brother, sister, etc.)	Living where? (home, school, etc.)

Please tell us about any past mental health treatment:

Therapy/counseling:

Prescriber:

Past psychiatric medication trials:

Medication	Dose	Duration	Side effects	Benefit or reason stopped?

Past suicide attempts or hospitalizations (list facility, dates; also list substance abuse rehabs):

Childhood History:

Please list any illness during the pregnancy or problems with delivery (C-section, etc):

Baby may have been exposed to the following, even before mom knew she was pregnant:

Prescription drugs tobacco alcohol marijuana/street drugs

Birth Weight:

Baby was born: on time early late

Problems during infancy: colicky feeding problems sleep problems other:

Age (if known):

Baby walked:	on time	early	late	_____
Baby talked:	on time	early	late	_____
Toilet-trained (bladder):	on time	early	late	_____
Toilet-trained (bowel):	on time	early	late	_____

If delayed, please explain and note if there are any ongoing concerns:

MEDICAL HISTORY:

Please list any history of head injury or seizure:

Please list surgeries:

Females only: If started menstrual cycles, are periods (circle) regular irregular

ALLERGIES (list medications, foods or other substances like latex):

Current Medications (please include over-the-counter meds, alternative or herbal remedies):

Medication	Dose	Instructions	Reason

Please CIRCLE any physical symptoms that your child complains of frequently:

Constitutional Change in appetite Change in energy fevers night sweats weight gain weight loss

Cardiovascular Chest pain exercise intolerance low blood pressure heart racing/irregular

Musculoskeletal Neck, back or joint pain stiffness swelling weakness

Eyes Eye symptoms visual changes **Respiratory** Cough Shortness of Breath snoring wheezing

Skin bruising itching rashes change in skin/hair

Endocrine intolerance to heat or cold excessive sweating neck swelling thirst (excessive)

ENT earaches nasal congestion nose bleeds sore throat

Gastrointestinal abdominal pain cramping or swelling constipation diarrhea indigestion nausea vomiting

Genitourinary pain with urination excessive urination irregular or heavy periods

B**reast** unusual enlargement/tenderness leakage from nipple

Hematologic bleeding (excessive) bruises easily lumps under arms/neck or groin

Neurologic headaches clumsiness dizziness numbness fainting tremor

Please let us know if your child or a family member have been diagnosed with any of the following:

Medical condition	**Child (patient)**	Mother	Father	Sibling (list bro or sis)	Mother's side	Father's side
Anxiety						
Bipolar disorder						
Heart Disease						
Depression						
Diabetes						
High Cholesterol						
High Blood Pressure						
Obesity						
Heart Defect						
Sudden death/arrthymia						
Suicide attempts						
ADHD						
Alcoholism						
Drug Abuse/Addiction						
Learning or intellectual disability						
Legal Problems						
Schiozphrenia						
Stroke						
Other: list below						

School History and Functioning:

Average report card grades: Last year? _____ This year?_____

What are your child's strengths?

What are your child's weaknesses?

List any problems your child has at school:	NO	YES	Describe:
attendance			
attention			
behavior			
homework			
peers			
teachers			
bus			

List any services that your child has received at school:	NO	YES	Describe:
Repeated a grade			
Early intervention			
IU services (intermediate unit)			
IST (instructional support)			
504 accommodations			
OT or PT			
Speech & Language			
School based mental health			
MDE (evaluation with psychological testing--IQ)			
IEP (special ed plan)			
special ed support (such as learning or emotional support, autistic support)			
Wraparound (BHRS—may include TSS, BSC or MT)			

Please Circle any stressors at home:

Separations from parent changes in home routine or composition

Financial problems marital problems moves

Death of loved one or pet other:

Are there weapons/guns in your home? NO YES

If yes, are they kept in a gun safe? NO YES

Has your child/teen gotten into any legal trouble? NO YES

Please list charges and probation officer. If truancy list fine.

Please check if your child has any abuse history:

	Victim	Perpetrator	Witness
Physical			
Sexual			
Emotional			
Neglect			

Was Children and Youth Involved? NO YES When?

Finally, is you child involved in any hobbies, clubs or sports?