Wellspring Counseling Center, Inc.
4305 S. Green Bay Rd.
Mt. Pleasant, WI 53406
(262) 883-9400
www.wellspringcc.com

Child and Adolescent Initial Assessment

Client Name:______________________________________Date:______________Age: _________

Birthdate:______________________ Sex:_____________ Soc. Sec. #: ______________________

Address:________________________________City:______________________Zip: ___________

Home Phone:__________________ Leave a Message? ☐ Yes ☐ No

Cell Phone:____________________ Leave a Message? ☐ Yes ☐ No

E-mail:______________________

Who has current custody/guardianship of child? ☐Mother ☐Father ☐Both Parents

☐Relative________________________________☐Other___________________________________

Parent/GuardianName:___________________________Spouse/Partner:______________________

Address (if different): ____

Home Phone: ___________________ Leave a Message? ☐ Yes ☐ No

Cell Phone: _____________________ Leave a Message? ☐ Yes ☐ No

E-mail:____

Birthdate:__________________ Age:______ Occupation:_________________________

Employer:____

Address: ____

Work Phone: ____________________ Leave a Message? ☐ Yes ☐ No

Referred By: ____

Where would you like us to leave reminder messages: Home _____Work _____Cell Phone _______

In the event of an emergency with client/child, whom should we contact?

Name:____

Relationship: _____________________

Work # ______________________________ Home # _____________________________________

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Child's Symptoms and Behaviors

Presenting Problem(s): Please state your concerns; specify nature of problem, duration, frequency, and severity:____

____

____

What are the most important issues you would like your child or teen to work on in therapy?

____

____

____

Does your child have behavior problems in the community (e.g. on probation, truancy, legal problems)?

____

____

Does your child have any past/current substance use/abuse? ☐cigarettes ☐drugs ☐alcohol
☐drugs and alcohol
☐ denies use ☐ remission 90+ days
☐none

If yes, please describe substances used, amount, and effect on child's performance at home and school:

____

____

____

Describe any abuse of substances that runs in the family:

____

____

____

Continued on next page.

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Please indicate how the following symptoms/problems/complaints are effecting your child/teen. Place the appropriate number in each box that applies (Leave blank if no effect).:

1)Little effect **2)Some effect** **3)Much effect** **4)Significant effect**

Isolates/ Withdraws	Generalized Anxiety	Weight Change
Irritability	Fatigue/ Decrease in Energy	Provokes Others
Panic Attacks	Frequent Angry Outbursts	Gang Involvement
Hyperactive	Increase or loss of Appetite	School Avoidance
Runs Away	Cruelty Towards Animals	Quick Tempered
Mood Swings	Aggression Towards Others	Sexual Behaviors
Separation Anxiety	Sees Things That Aren't There	Speech Difficulties
Tearfulness	Difficulty Concentrating	Little or No Friends
Racing Thoughts	Self-Harming Behaviors / Cutting	Poor Social Skills
Breaks the Law	Frequent Stomachaches / Headaches	Binging / Purging
Bullied by Others	Suicidal Thoughts / Attempts	Cries Easily
Learning Problems	Loss of Interest in Activities	Frequent Fighting
Steals	Wets/Soils Bed or Clothes	Nightmares
Worry / Fear	Fire-Setting / Play with Fire	Hopelessness
Sadness	Problems Falling or Staying Asleep	Repetitive Movements
Disobedient / Defiant	Inattentive /Distractible	Hearing Voices

Continued on next page.

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Child's School History

Current School District: ______________________________________Grade:____________

School Name: ___________________________________ Phone #: ___________________

Review history of school functioning including strengths: (Gifted or accelerated learning program, learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement):

____

____

____

Teacher/Counselor/IEP Coordinator: ____

Is child enrolled in special education? ☐Yes ☐No Current IEP? (if yes, request copy)

Child is designated: ☐Emotionally Disturbed (ED) ☐Specific Learning Disability (SLD)

☐ Other_______

Child's classroom is: ☐Regular Education ☐Regular Education with pull-out to Resource Room

☐ Special Education classroom (all day) ☐Inclusion in regular education (________ hours/day)

☐Other: ____

What school interventions have been used to address problems:

☐None ☐Special seating arrangement ☐Tutoring ☐Groups ☐Classroom aide ☐Parent(s) called

☐other: ____

Has the child been suspended/expelled in past 12 months?☐Yes ☐No If yes, how many times and the reason(s)? ____

____

____

____

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Child's Health

Starting with birth and proceeding up to the present, list all allergies, diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had:

____

____

____

____

____

Has your child ever had any previous psychotherapy? If so, where, how long, and did you feel it was helpful?

____

____

____

____

Physician Name and Number: ____

Date of Last Visit: ___________

Psychiatrist Name and Number: ____

Date of Last Visit: ___________

Prescribed medications:	**Purpose:**	**Dose:**	**Side Effects:**

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Family Relationships

Relatives That Live in the Home:	Name:	Age:	Occupation:	Describe Relationship With Child:
Father				
Mother				
Brother (s)				
Sister (s)				
Step-Father				
Step-Mother				
Step-Brother (s)				
Step-Sister (s)				
Other				
Other				

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

____

____

____

Please describe significant events in your family life that may have had an impact on your child (i.e. major moves, changes in school, divorce, loss of a loved one, abuse and/or assault of any kind, legal troubles): ____

____

____

____

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Developmental History:

Please note the age at which the following behaviors took place.

Weaned: ________	Dry during day: ________	Dry during night: ________	Toilet trained: ________	Fed self: ________
First words: ________	Spoke sentences: ________	Sat unassisted: ________	Crawled: _______	Took first steps: ________
Dressed self: ________	Tied shoe laces: ________	Rode two-wheeled bike:________	First Teeth: _______	Age Entered School: __________

Please describe your child's early development. Please include any complications like feeding problems, developmental delays, colic, chronic illnesses, etc.:

____

____

____

____

Signature of Client/Legal Representative

____Date: __________________

Print Name: ____

Signature of Client/Legal Representative

____ Date: __________________

Print Name: ____