CHILD AND ADOLESCENT

To be completed by the client or parent on behalf of the client to provide information that will be helpful in developing how treatment is provided.

Yes❑ No❑ 1. Does faith or religion provide the child resources such as ❑ hope, ❑ prayer, ❑ meaning, ❑comfort, ❑ community, ❑ other?

Yes❑ No❑ 2. Will the child/adolescent/family's religious beliefs affect the way services are planned?

Yes❑ No❑ 3. Has the child/adolescent ever been involved in court proceedings or had legal problems?

❑ Custody ❑ Incarceration/juvenile detention
❑ Probation/parole ❑ Other _____

Yes❑ No❑ 4. Does the child/adolescent have any current or pending legal issues that would affect the way services are planned?

Yes❑ No❑ 5. Does the child/adolescent experience difficulty with any of the following? If yes, explain.

❑ Reading _____
❑ Speaking _____
❑ Hearing _____
❑ Learning _____
❑ Other _____

For Parents Only:

Yes❑ No❑ 6. Do you have concerns about the safety or suitability (e.g., heating in winter) of your home or neighborhood?

Yes❑ No❑ 7. Is it difficult to take care of your family on your current income?

Yes❑ No❑ 8. Has the child/adolescent witnessed domestic violence?

To be completed to assist the clinician to determine the need for additional screening

Yes❑ No❑ 9. Is the child/adolescent having any problems at school?
❑ Academic/learning ❑ Behavior

Yes❑ No❑ 10. Has the child/adolescent used any drugs, alcohol, or participated in any gambling?

Yes❑ No❑ 11. Has the child/adolescent ever experienced abuse/neglect?
❑ Physical abuse ❑ Neglect
❑ Sexual abuse ❑ Exploitation

Yes❑ No❑ 12. Is the child delayed in any developmental tasks?

Yes❑ No❑ 13. Does the child/adolescent have thoughts of hurting self or others?

Completed by _____

Reviewed by _____ Date_____

Name:

Client ID: DOB:

Oaklawn Psychiatric Center
SELF-REPORT – CHILD AND ADOLESCENT

Client ID | Document Date

SELF REP CHILD

ASSESSMENT SUMMARY

POP