

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?

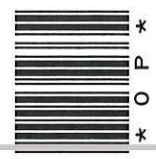
Completed by _____

Reviewed by _____

Date _____

Form No. 53 Rev. 3/12

Name:	
Client ID:	DOB:
Oaklawn Psychiatric Center	
SELF-REPORT – CHILD AND ADOLESCENT	



Client ID

Document Date