

PSYCHOLOGICAL SERVICES

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Mt. Diablo Psychological Services

TEEN/FAMILY ASSESSMENT Client Name: _____ Date: _____ Name of person filling out form: ______ Relation to client: **School information:** School Name: Grade: **School Counselor Name:** Phone Number: Email address: _____ What problems does your child currently have in school? (Check all that apply) Attendance problems Individualized education plan (IEP), Started at what Grade: Poor grades Held back Behavioral problems Details: Social problems Details: Expelled When:_____ Why:____ Suspended When:_____ Why: _____

What problems does your child currently have at home? (Check all that apply) Doesn't do chores Sneaks out Poor communication Fights with siblings Runs away Doesn't comply with limits and consequences Other:							
What is the family structure? Relationship				Anything we should know about the			
- Toldilollollo	, .9	o occupation		relationship?			
Biological Mother							
Biological Father							
Stepmother							
Stepfather							
Adopted Mother							
Adopted Fath	er						
Other:							
Who currently lives in your home?							
Name	Age	Relationship		ything we should know about the ationship?			

Is your child from a divorced home?	No Yes
Age at time of divorce?	
How did child respond to the divorce?	
Is your child adopted?	NoYes
Age at time of adoption	
Country of origin	
Notable circumstances?	
Is there a family history of any of the following Aggression, oppositional behavior Describe: Attention, hyperactivity, impulsivity	r
Describe:Psychosis, schizophrenia Describe:	
Mood problems, depression Describe:	
Anxiety problems, excessive work Describe:	•
Substance abuse Describe:	
Legal problems Describe:	
Suicidalilty, self-harm	

Are there any current family stressors that seem relevant to your child's difficulties?
Developmental History:
Complications during pregnancy? No Yes If Yes, please provide details:
Substance use during pregnancy No Yes If Yes, please provide details:
Were there problems with your child's development? (Check those that apply) Motor development (walking, coordination, balance) Speech development (stuttering, speaking) Sensory development (vision, hearing, reactions to noise) Cognitive development (unusual thoughts, odd ideas/fantasies) Academic development (learning problems, ADHD)
Details:
Has your child experienced any significant disruptions to attachment in their life, such as: Bullying/Peer aggression Chronic Illness/Death of significant person in their life Other (Describe):
If yes to any of the above, please provide details:
Between ages 0-3, what were the child care arrangements?

Has your child ever had a cognitive or psychological assessment done (e.g in the hospital or for an IEP)?NoYes If Yes, please provide details:
List your child's strengths and interests:
How does your teen respond to discipline?
Behavior Change: How have you tried to treat issues with your teen in the past? (Check all that apply)TherapyTherapeutic (or other) programsDisciplineIncentives/rewards programSchool consultation/Communication with teachersReligious consultationOther/describe:
Are there any forms of discipline, which you have found to be especially effective or ineffective?
Is there anything else you would like us to know about your teen or your family?