ASCENT PSYCHOTHERAPY CENTER	Name:		
	Date of Birth:		
	Gender:	❑ Male	❑ Female
	Date of Evaluation:		

IDENTIFYING INFORMATION:

Name of the person providing information:	Relationship to patient:
Name of the legal guardian (if different from above):	Ethnicity/Race:

REFERRAL SOUCE:

__Physician/Therapist: Name:_____ Phone:_____

Are you permitting us to share information with the referring profession? __Yes __No

____Insurance ____Family/Friend ____Existing Client ____Internet ____Phone Book ____other:

REASONS FOR EVALUATION:

__Continuation of care for exiting psychiatric condition: __Stable on current treatment __Not stable on current treatment

__Need consultation or second opinion for existing psychiatric condition

__Existing psychiatric condition has worsened and need an evaluation

__Child was recently discharged from a psychiatric hospital and is here for follow-up care

__I am here for my child's first psychotherapy evaluation because:_____

Is your child currently exhibiting, or has exhibited in the past, any of the following:

___Difficulties with attention & focus	___Hyperactivity or fidgetiness	___Behavioral issues at school
___Uncontrollable anger/rage	___Aggression toward others	___Rapid changes in mood
___Mood swings and irritability	___Destruction of property	___Learning difficulties
___Poor academic functioning	___Difficulty getting along with peers	___Depression/isolation
___Anxiousness/excessive worrying	___Self-injurious behavior	___Suicidal thoughts/behavior
___Difficulties with rules & authority	___Frequent lying, stealing, or breaking law	___Engaging in ritualistic behavior
___Loss of interest in fun/routine activities	___Difficulty handling change	___Difficulties with communication skills
___Difficulties with social skills	___Delay in language development	___Socially inappropriate behavior
___Using/abusing alcohol or illicit drugs	___Hearing voices/seeing things that aren't there	___Using/abusing tobacco products
___Other:		

Please provide some details on the nature of the problem(s) noted above:_____

How long has your child been experiencing these problems? _____

Are there any major stressors currently or in the recent past that may be affecting the child's current problem(s)? (ex. parent's divorce, relocation, death, abuse, accident, trauma, financial, etc.)_____

PAST & CURRENT PSYCHIATRIC HISTORY:

❑ ADD/ADHD	❑ Oppositional/Defiant Disorder	❑ Conduct disorder	❑ Depression
❑ Anxiety disorder	❑ Bipolar disorder	❑ Autism/PDD	❑ Asperger's Disorder
❑ Eating disorder	❑ Tic/Tourette's	❑ Schizophrenia	❑ Obsessive-compulsive disorder
❑ Psychosis	❑ Panic attacks		

Please provide a brief history, if known, including the age on onset and treatment for each of the conditions marked above:

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Please provide the name and contact information of the previous Physician/Therapist:_____

_____

Past Psychiatric hospitalizations ❑ None ❑ Unknown ❑ Yes (provide the information below with the most recent first)

Name	Date (approx.)	Reason for Admission	How many days

FAMILY HISTORY: ❑None ❑Unknown ❑Yes (check all that apply)

❑ Depression	❑ Suicide	❑ Bipolar disorder	❑ Schizophrenia	❑ Anxiety/Panic do
❑ ADD/ADHD	❑ Alcohol abuse	❑ Cocaine abuse	❑ Tobacco use	❑ Nervous Breakdown
❑ Family Violence	❑ Aggression/Anger	❑ Eating disorder	❑ Autism/PDD	❑ Weight problems
❑ Diabetes	❑ High blood pressure	❑ Heart disease	❑ Other:_____	

For each of the conditions marked, tell us the relationship to the client (ex: mother, father, uncle, grandparents, etc.):

_____

_____

_____

HEALTH & DEVELOPMENTAL HISTORY:

How would you describe the health of your child: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Any allergies to medications: ❑ None ❑ Yes (provide details): _____
Ay allergies to food: ❑ None ❑ Yes (provide details): _____
Date of last medical checkup: _____ Outcome: ❑ No Issues ❑ Issues, details:_____
Current pediatrician/PCP? Name: _____ Contact: _____

Has your child had or currently have any of the following:

❑ Asthma/Allergies	❑ Seizures/Epilepsy	❑ Heart defects/heart disease	❑ High cholesterol
❑ Meningitis/Encephalitis	❑ Anemia	❑ Hearing problems	❑ Frequent ear infections
❑ Kidney problems	❑ Liver problems	❑ Head injury (loss of consciousness, concussions, bleeding, etc.)	
❑ Bedwetting	❑ Any genetic/metabolic disease		❑ Dental problem
❑ Digestive problems	❑ Seizures	❑ Diabetes	❑ Strep infections
❑ Feeding problems	❑ Speech problems	❑ Encopresis	
❑ MRI/PET/CT Brain Scan (date:_____)		❑ EEG (date:_____)	❑ EKG (date:_____)

❑ Other:_____
❑ Surgeries/Hospitalizations:_____
❑ Any other serious illness: _____
For each of the conditions marked, please give details on current status, severity, age of onset, etc?

_____

_____

_____

Current Medications: ❑ None ❑ Yes, please list them below:

Name	Dose & Frequency	Date started	Reason	Prescribing MD/APRN

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Was your child adopted? ❑Yes ❑No If yes, at what age? _____

Pregnancy and Birth History: ❑ No history available ❑ Partial/full history available (please provide information below)

Duration of pregnancy? _____weeks/months Child's birth weight? _____pounds _____ounces

Mother's age at birth?_____ Did mother receive prenatal care?_____

Child's Apgar score?_____ Did mother take any medications during pregnancy?_____

Pregnancy course? ❑ Normal ❑ Physical injury ❑ Hypertension ❑ Diabetes ❑ Smoking ❑ Alcohol ❑ Drugs ❑ Other?

Delivery/labor? ❑ Normal ❑ Induced labor ❑ C-Section ❑ Breech ❑ Prolonged labor (>12 hrs) ❑ Forceps ❑ Other?

Condition at birth ❑Normal ❑ Lack of oxygen ❑ Breathing problems ❑ Birth injury/defects ❑ Jaundice ❑ ICU?

Other information?

Developmental milestones: ❑ No history available ❑ Partial/full history available (please provide the information below)

❑ Within normal limits (to the best of my knowledge; details not available)

Sat up without help at _____months; Walked upstairs at _____months; Spoke sentences at _____months;

Crawled at _____months; Spoke first words at_____months; Fully bladder trained at _____months;

Walked alone at _____months; Spoke short phrases at _____months; Fully bowel trained at _____months;

Any other information regarding early childhood/development? (physical issues, behavior issues, social issues, etc.)_____

_____

_____

BEHAVIORAL HISTORY:

A. Infancy: During your child's first few years of life, was any of the following present to any significant degree?

- ❑ Did not enjoy cuddling
- ❑ Was not easily calmed by being held or stroked
- ❑ Difficult to comfort
- ❑ Colicky
- ❑ Excessive irritability
- ❑ Diminished sleep
- ❑ Difficulty nursing
- ❑ Poor eye contact; did not turn toward caregivers
- ❑ Did not respond to name or speech of caregivers
- ❑ Fascination with certain objects
- ❑ Constantly getting into everything
- ❑ Frequent head banging

Comments:

B. Toddler through five years of age:

How active has your child been from an early age?

❑ hyperactive ❑ very active ❑ age appropriate ❑ less active than peers ❑ mostly inactive ❑ other

How well was your child able to maintain focus, concentrate, or pay attention to tasks?

❑ very well ❑ fairly well ❑ not very well ❑ couldn't focus at all ❑ other:

How well was your child able to deal with transitions, chnge, or when denied his/her way?

❑ very well ❑ fairly well ❑ not very well ❑ threw tantrums ❑ complete meltdown ❑ other

Whether happy/unhappy, how strong were your child's feelings exhibited?

❑ very intense ❑ somewhat intense ❑ age appropriate ❑ less than normal intensity ❑ no emotions/feelings ❑ other

What was your child's basic mood?

❑ happy ❑ whiny ❑ sad/gloomy ❑ irritable ❑ angry ❑ unpredictable (highs/lows) ❑ other

Did your child exhibit frequent or rapid changes in mood or temperament?

❑ not at all ❑ sometimes ❑ very often ❑ all the time ❑ other

How predictable were your child's patterns of activity level, sleep, appetite, etc?

❑ very predictable ❑ mostly predictable ❑ mostly unpredictable ❑ always predictable ❑ other

Comments: _____

_____

_____

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HOME AND LIVING SITUATION:

Whom does the child live with: ❑ both parents ❑ bio mother ❑ bio father ❑ guardian ❑ other:_____
Are biological parents of child currently: ❑ married? ❑ separated ❑ divorced ❑ never married ❑ other: _____
If biological parents are separated/divorced who has legal custody?: ❑ mother ❑ father ❑ joint ❑ other: _____
How do you feel your child has adjusted to the separation/divorce?_____
Are there other adults who have significant part in raising your child? ❑ No ❑ Yes If yes, please specify the name and relationship (step-parent, grandparent, boy/girlfriend, etc.)_____

How many brothers and sisters does your child have and where does your child rank from oldest to youngest?

Who lives in the same household as the child? _____
What's the primary language spoken at home? _____
Have there been any significant changes in the home over the last few years? (such as new marriages, divorce, deaths, births, change of residence, parent job change/loss, money problems, health issues, etc,): _____

Is there any history of abuse or CPS involvement? ❑ No ❑ Yes, please explain: _____

Has your child ever gotten into a legal problems/arrested? ❑ No ❑ Yes, please explain: _____
Does your child have pending legal problems? ❑ No ❑ Yes, please explain: _____
How does your child relate to others at home? ❑ friendly ❑ withdrawn ❑ fights with siblings ❑ hostile ❑ unfriendly ❑ normal ❑ other? _____
Does your child follow all the rules and respect others? ❑ all the time ❑ mostly ❑ sometimes ❑ not at all
List some of your child's strengths:_____
List some of your child's weaknesses: _____
Which adult would your child prefer to talk with about a problem?_____
Who is the family member your child feels closest to? _____
Who is primarily responsible for discipline in the home?_____
What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, time-out, grounding, reward, etc.)

Does your discipline methods works? ❑ most of the time ❑ sometimes ❑ rarely ❑ make it even worse
List some of the responsibilities/chores your child has at home: _____
Does your child do these chores regularly? ❑ Yes ❑ Sometimes ❑ Not at all ❑ Need reminders
What time does your child go to bed?_____ What time does your child awaken?_____ Does your child sleep well?_____

RECREATION:

What kind(s) of exercise does your child get? _____
In what after school activities does your child participate? _____

Does your child play video games? ❑ Yes ❑ No
If so, which ones?_____
How much time does your child typically spend on entertainment? ❑ TV____hrs/day; ❑ Video games ___hrs/day other: _____
Does your child have a television or computer in his/her room? ❑ Yes ❑ No
Does your child have his/her own cell phone? ❑ Yes ❑ No
How often does your child visit with his or her friends? _____
What do you think about your child's group of friends? _____
Any other information?_____

EDUCATIONAL HISTORY:

Current Grade?_____ Name of the school and school district?_____
How are his/her grades?_____
What is your child's best subject?_____ Worst subject?_____
What does your child's teacher say about your child?_____
How does your child feel about school/learning? ❑ very motivated ❑ neutral ❑ has poor motivation ❑ doesn't care
How much time does your child spends on homework each night?_____
How much of a struggle is homework? ❑ Not a struggle ❑ Sometimes a struggle ❑ Often a struggle
Does your child receive special school services? ❑ No ❑ Yes If yes, which program(s) and when did services begin?

Has your child ever been held back in school? ❑ No ❑ Yes in _____grade(s)
How would you describe your child's current academic performance? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Failing
How would you describe your child's current behavior in school? ❑ Friendly ❑ Outgoing ❑ Shy ❑ Loner ❑ Awkward ❑ Aggressive

TRAUMA HISTORY:

To your knowledge, was your child ever physically, verbally, or sexually abused? _____
If so, please briefly describe: _____
Has this been reported to local authorities/CPS? ❑ Yes ❑ No If no, are you willing to report it? ❑ Yes ❑ No (If no, counselor mandated to report).
Has your child ever experienced the loss or death of a close loved one? ❑ Yes ❑ No
If so, please briefly describe circumstances: _____

SPIRITUALITY:

Does your family belong to a particular religion or spiritual group: ❑ Yes ❑ No
If yes, what type of religion/spiritual group does your family prefer?_____
If yes, what is the level of your family's involvement? _____
If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is particularly important to you? ❑ Yes ❑ No
Please explain: _____

ADDITIONAL INFORMATION: