KW COUNSELING SERVICES, LLC

Assessment Information for Children and Adolescents

Child's Name:_______________________________________ Today's Date:________________

Child's Date of Birth:__________________________________ Grade in School: _____________

Who referred you to this office?____

1. How old is your child?____________________

2. What are your current concerns related to you child today?

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3. What is the quality of your family relationship at this time?_____________________________

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4. Are there school issues that you are concerned about? If so, please describe:_____________

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5. Are there drug/alcohol issues related to your child/adolescent? If so, what are they?

____

6. Is your family involved with the Department of Human Services or Juvenil Court? If so, how and why?____

____

7. What issues bring your child to counseling at this time?

________Depression ________Anxiety ________Family ________Adjustment

________School ________Divorce/Separation ________Grief

________Physical Abuse ________Sexual Abuse

Other issues; please describe in as much detail as possible:

____

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____

continue on next page

8. Is your child experiencing any of the following?

______Guilt	______Poor Appetite	______Fatigue
______Panic/Anxiety	______Loss of Interest	______Irritability
______Sexual Issues	______Trouble Concentrating	______Worry
______Trouble Sleeping	______Feelings of Hopelessness	______Aggression
______Wetting/soiling	______Tantrums	______Nightmares
______Poor Boundaries	______Touching others inappropriately	

Other significant problems/behaviors? Please explain:

____

____

9. Has your child ever had any counseling before? If so, with whom and for how long? _______

____

When? _______________ For what issues? ____

10. Have others in your family received counseling services before today? If so, where and when? ____

Who in your family participated in counseling sessions?

____

11. Is your child taking any medication currently? __________ If so, what medication and dose?

____

Who monitors this medication? ____

12. Does anyone in your family have issues with drugs/alcohol? Please describe: ____________

____

13. Is there a family history of mental health issues, drug and alcohol use, domestic violence or criminal activity? Please describe: ____

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14. Is there anything else about your child and your family that might be helpful to the counseling process? If yes, pleas describe: ____

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_________________________________ _________________________________

Guardians Signature Relationship to child