Carolina Counseling Services

Child/Adolescent Comprehensive Clinical Assessment

***** If there are any custody issues involving this child, please see one of our office staff immediately so that we may refer you to a therapist who specializes in those issues. Currently, none of our therapists will be able to assist you. We apologize for any inconvenience*****

Medical History

Name_____ Date of Birth_____ Age_____ Gender ___M ___ F

Name of Primary Care Physician_____

Physician's Address_____ Physician's Phone_____

Date of Last Medical Examination_____ Date of Next Appointment_____

What Previous Therapy has this child had? Please describe_____

_____

Family History

Please check all the information which applies to your child's biological parents:

MOTHER:	FATHER:
____ living	____ living
____ deceased	____ deceased
____ married	____ married
____ divorced	____ divorced
____ living with someone	____ living with someone
____ remarried _____# of times	____ remarried_____# of times

With whom does the child live: _____

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse_____

Sexual/Physical/Emotional abuse_____

Please check any of the following that describe how you believe your child has been feeling lately:

___ sad ___anxious ___ depressed ___ frightened ___ guilty ___angry ___ ashamed ___ aggressive ___ resentful ___ worthless

___ tearful ___ irritable ___confused ___extreme ups/downs ___jealous ___hopeless ___ helpless

Describe any other feelings you have had that was not listed above._____

Please check any of the following risk-taking behaviors that the child has been engaged in:

___ street racing ___gang involvement ___ skipping school ___dropped out ___ dangerous dieting ___cutting ___stealing ___unprotected sex ___running away

___bullying others ___fire starting ___hurting small animals ___restricting food intake ___over exercise ___drinking alcohol ___using drugs

Please check any of the following alcohol/drugs that the child has used:

___beer ___wine ___hard liquor ___pot/marijuana ___cocaine ___heroin ___Ecstasy ___speed ___over the counter drugs

___prescription drugs ___Triple C's ___dons ___quad bars other_____

Has your child ever considered or attempted suicide in connection with the current problem? _____

Has your child ever considered or attempted suicide in the past? _____

Has your child tried to hurt others or animals recently or in the past? _____

Has your child had any homicidal thoughts recently or in the past? _____

Please list your therapy goals:

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____