Family Service
OF THE PIEDMONT

Name:	**D.O.B.**: _/_/
F.S.P.#:	
Medicaid #:	**IPRS / LME #**:

DATE OF ASSESSMENT_____

Children's Basic Assessment

Thanks for choosing Family Service of the Piedmont. We're glad you are here. Please read the following questions carefully, and answer the questions. Your counselor will go over the information with you in more detail.

Social / Vocational / Educational History:

What is the marital status of your parent(s)? ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow(er)
Do you live with your parents? ☐ Yes ☐ No If ***you chose No, Who do you currently live with?***
☐ Grandparents ☐ Foster Parents ☐ Aunt/Uncle ☐ O ther (If other please explain below): _____

_____

_____

Have you ever lived somewhere else other than your parents' house? ☐ Yes ☐ No **If yes, please choose and/or explain below:**
☐ Grandparents ☐ Foster Parents ☐ Aunt/Uncle ☐ Group Home ☐ Other – Please explain below:

_____

_____

_____

Do you have any siblings (sister/brother/step-sister/step-brother)? ☐ Yes ☐ No **Do they live with you**? ☐ Yes ☐ No If Yes, list your siblings and their ages:

NAME _____ **Age** _____

NAME _____ **Age** _____

NAME _____ **Age** _____

NAME _____ **Age** _____

Are there currently other people living in your home with you? ☐ Yes ☐ No (If yes, please explain): _____

_____

Were/are your parent(s)/guardian(s) supportive/helpful towards **each other**? ☐ Yes ☐ No Explain: _____

_____

Were/are your parent(s)/guardian(s) supportive/helpful towards **you**? ☐ Yes ☐ No Explain:

_____

_____

_____

What are (if any) the main problems/stressors between you and your parent(s)/guardian(s)? _____

_____

_____

Family Service
OF THE PIEDMONT

Name:	**D.O.B.**: _/_/
F.S.P.#:	
Medicaid #:	**IPRS / LME #**:

Do you have any problems with other people in your family? ☐ Yes ☐ No (If yes, please explain): _____

_____

_____

Are your parent(s)/guardian(s) currently involved with or have been involved with any social service agency (CPS/DSS)?
☐ Yes ☐ No If Yes, explain why and when: _____

_____

_____

Does your parent/guardian work? ☐ Yes ☐ No ☐ I don't know (If yes, where does your parent/guardian work):

_____

Do **you** work? ☐ Yes ☐ No ***If Yes, then where and how many hours***?_____

What school do you go to? _____ What grade are you in? _____

What are your favorite and least favorite classes in school?_____

What kind of grades do you get in school (***A, B,C, D, F***)?_____

How do you get along with your teachers? ☐ Good ☐ Not very good ☐ Bad ☐ Little/No interaction

Do you participate in extra-curricular activities? (Sports, clubs, youth group, scouts):_____

_____

Have you ever been suspended or expelled from school? ☐Yes ☐No (If yes, explain):_____

_____

_____

Were/are your parent(s)/guardian(s) involved in **your** school/extra-curricular activities? ☐ Yes ☐ No (If yes, explain):

_____

Were/are your parent(s)/guardian(s) involved with your friends/in your relationships? ☐ Yes ☐ No (If yes, explain):

_____

Have your parent(s)/guardian(s) ever been in trouble with the law/legal system? ☐ Yes ☐ No (If yes, explain):

_____

Have you ever been a victim of physical abuse, sexual abuse, or neglect? ☐Yes ☐No (If Yes, please explain):

_____

_____

If you answered ***yes*** to the above, was it reported? ☐ Yes ☐ No (If Yes, to who and when)? _____

_____

_____

Is there any history of substance abuse/drinking alcohol/drugs in your family? ☐ Yes ☐ No If Yes, explain:_____

_____

_____

Has there been any significant family events (death, illnesses, job loss, relocation, financial, etc.)? ☐ Yes ☐ No

_____

_____

Family Service
OF THE PIEDMONT

Name:	**D.O.B.**: _/_/
F.S.P.#:	
Medicaid #:	**IPRS / LME #**:

Medical/Psychiatric/Legal History:

Do you have Allergies? ☐ Yes ☐ No If yes, list: _____

_____

_____

Who is your primary care doctor/Pediatrician and when was your last visit?

_____

Who is your dentist and when was your last visit?

_____

Do you take any medications given/prescribed to you by a doctor? ☐ Yes ☐ No If Yes, list: _____

_____

_____

Who helps you take your medicine? _____

Do you take any medication not given to you by a doctor (e.g. vitamins, Aspirin)? ☐ Yes ☐ No If Yes, list: _____

_____

_____

Do you have any chronic illnesses such as Diabetes, ADHD/ADD, functioning (movement) or cognitive (mind/brain) impairments, etc.? ☐Yes ☐No If yes, please list: _____

Have you ever been charged/convicted of a violent crime? ☐Yes ☐No If Yes, please explain below:

_____

_____

Have you ever spent any time in a Juvenile Detention Center? ☐Yes ☐No If Yes, please explain below:

_____

_____

Do you have any problems with the following:

☐ Physical Outbursts	☐ Verbal Outbursts
☐ Anxiety	☐ Low Self Esteem
☐ Depression	☐ Trouble Sleeping
☐ Self-Harm	☐ Nightmares
☐ Suicidal Thoughts/Attempts	☐ Decrease/Increase appetite
☐ Dangerous and/or Age Inappropriate Sexual Behavior	☐ Drug/Alcohol use

Other:_____

_____

_____

What do you most want help with today:

_____

(For parent/guardian) What do you most want your child to get help for today?:_____

_____

_____