Heartwood Counseling
Peggy C Mahan, MA, LPC, Play Therapist

heartwoodcounseling.com

Adolescent Psychosocial Assessment

Intake Date_____

Client Name_____ Male____ Female____

DOB ___/____/_____ Age____ Grade_____ School_____
Home Address_____
_____
_____

Parent or Legal Guardian Name(s)_____

DOB___/____/_____ Age_____ Male/Female
Address_____
_____
_____
Home #_____
Cell #_____
Email_____
Referred by_____
Employed ___ Yes ___ No
Occupation_____
Employer_____

DOB___/____/_____ Age_____ Male/Female
Address_____
_____
_____
Home #_____
Cell #_____
Email_____
Referred by_____
Employed ___ Yes ___ No
Occupation_____
Employer_____

Presenting Issues that bring you here today?
_____
_____
_____
_____
_____
_____
_____
_____
_____

Household Family Member Names and Ages:

_____

_____

_____

Other Family Members Living Outside the Home

_____

_____

_____

_____

Are there any specific learning needs I should be aware of?

_____

_____

_____

_____

CHEMICAL USE HISTORY

Is your child currently taking prescription medication? ___ Yes ___ No

What is the name of the medication? _____ Dosage? _____

Physician name and phone_____

Psychiatrist name and phone_____

And for what reasons? _____

_____

PHYSCIAL AND MENTAL HEALTH

Has your child had a serious illness in the past 12 months? ___ Yes ___ No

If yes, please explain. _____

_____

_____

Has your child ever seen a counselor or therapist before? ___ Yes ___ No

If yes, please explain. _____

_____

_____

Has your child ever been hospitalized for a mental illness? ___ Yes ___ No

Please circle any of the following your child has experienced over the past 12 months.

Trouble Sleeping Sleeps too much Lack of appetite Headaches

Dizziness Memory Problems Lack of energy Isolation

Overly active Anxiety Restricts Food Over Eats Negative body image

Self esteem issues Cries often Self injurious behavior Identity concerns

Hearing voices Depression Temper outbursts Mood swings Lost interest in activities

Seeing things not there Thoughts of hurting others Thoughts of hurting self

Verbally aggressive Physical, sexual or emotional abuse Grief/ Loss Divorce

Head injury (THI) Intrusive Thoughts Illegal Drug Use Phobias Sexually Active

Has your child ever threatened or attempted suicide? ___ Yes ___ No

If yes, please explain. _____

_____

_____

_____

_____

Is your child acting out at school, home, or in public? Please explain. _____

_____

_____

Is your child acting out physically toward others?
Punching _____ Kicking _____ Slapping _____
Is your child acting out sexually?

Being age innapropriate with adults of the opposite sex or same sex?

Is your child defiant or rebellious? Please explain.

_____

_____

How long have any of the above been present? (Please list the symptom or behaviors as well as the length of time.)

Are any of the behaviors or symptoms recurrent? Please explain.

Were there any irregularities in the pregnancy or the birth of this child? Explain.

What major changes have occured during the child's lifetime? (births, deaths, moves, changes in schools, divorce or separation, new pets, death of pets, anyone move in or out of the household, any major surgeries or hospitalizations?

Which of these have occurred in the past year?

_____

_____

_____

What else do you think I should know about your child?

_____

_____

_____

_____

_____

_____

How did you hear about Heartwood Counseling?

_____

_____

_____

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