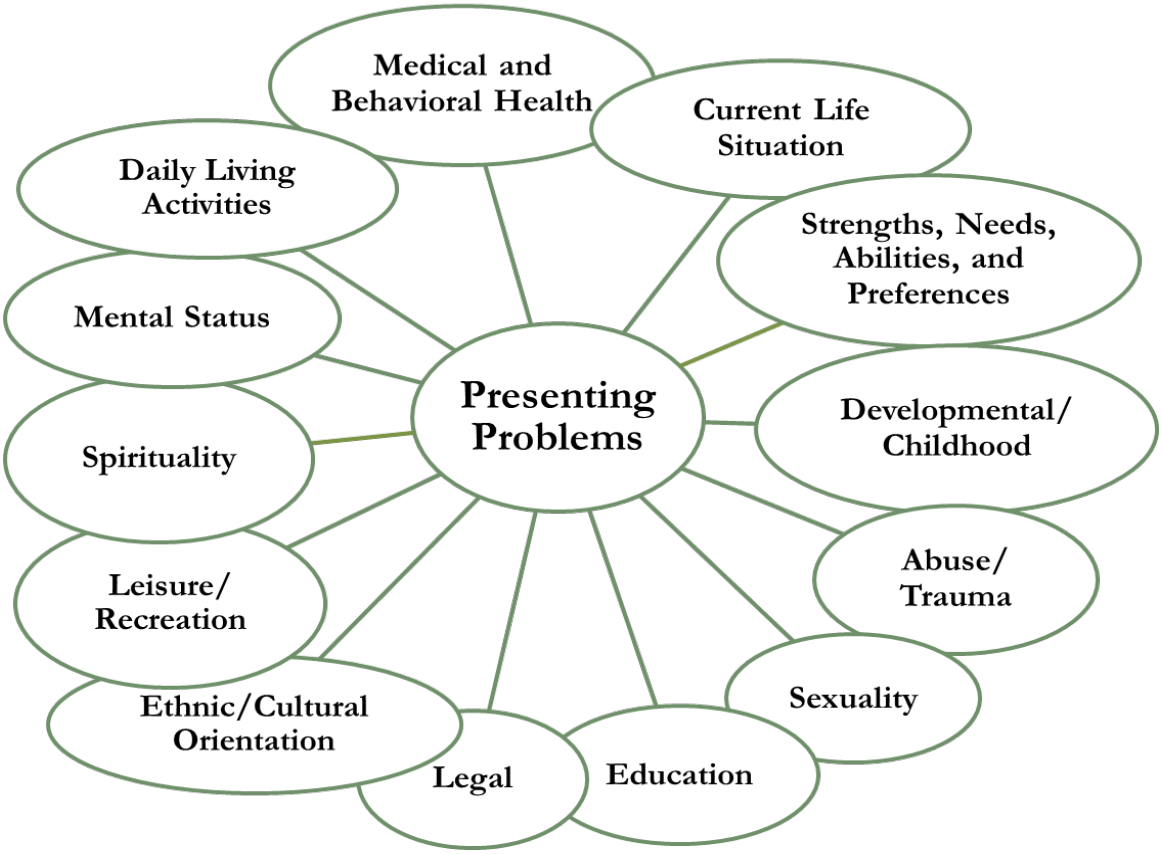
HIGH COUNTRY BEHAVIORAL HEALTH
CHILD COMPREHENSIVE ASSESSMENT

A comprehensive assessment helps us to understand your child's present life circumstances and the problems that are interfering with his/her overall quality of life.

GOOD TREATMENT BEGINS WITH A GOOD ASSESSMENT



From the information gathered during the assessment we formulate:

1. **A diagnosis,**
2. **A prioritized list of problems and needs, and**
3. **A treatment plan with measurable goals and objectives to address the problems and needs you have identified.**

The child assessment is intended for youth who are 12 years old and under. Parents or legal guardians help to complete the child's assessment.

It may take 1-2 sessions to complete the assessment process. Then we can develop a treatment plan to resolve your child's presenting problems.

HIGH COUNTRY BEHAVIORAL HEALTH
CHILD COMPREHENSIVE ASSESSMENT

IDENTIFYING INFORMATION

1.Name:_____
Last First Middle Initial

2. Address: _____
Street Address City State Zip

3. Phone: _____

4. Date of Birth:___/___/___ 5. Age:_____ 6. Gender: _____

5. Name of parent or legal guardian who assisted in the completion of the assessment:_____

PRESENTING PROBLEM(s)

1. Please describe why you are seeking help for your child at this time and how long these problems have been occurring:
2. What are the circumstances that seem to make the problem(s) worse?:
3. What interventions or treatments have you previously tried to resolve the problem(s): (what has helped or has not helped with the problems)
4. Has your child been thinking of hurting self or others? Has she/he been feeling suicidal? Have there ever been attempts to commit suicide? If so, how many attempts have been made and what were the methods?

CURRENT LIFE SITUATION

1. What are the child's current living arrangements: (where; how many in household; how are relationships and support)

2. How long has the child lived in these current arrangements? _____ Is the child satisfied with this? ❑Yes ❑No

3. Will transportation to and from treatment be a barrier to attend treatment?: ❑ Yes ❑ No

4. How would you describe the child's current quality of your life? ❑Excellent ❑Good ❑Fair ❑Poor

8. What seems to interfere the most with your child's current quality of life?

9. How supportive are other adult care givers in your child's life?:

Aunts, uncles, grandparents, neighbors, friends of family, older siblings, etc.	Age	How supportive is the relationship:	How long has your child known this person?
		❑Excellent ❑Good ❑Fair ❑Poor Why?	
		❑Excellent ❑Good ❑Fair ❑Poor Why?	
		❑Excellent ❑Good ❑Fair ❑Poor Why?	
		❑Excellent ❑Good ❑Fair ❑Poor Why?	

10. **During the past 90 days** have there been issues in your child's current life situation that are related to the presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated is the child to address these in counseling? Please explain:

MEDICAL AND BEHAVIORAL HEALTH HISTORY

Medical History (List all major illness, surgeries, major injuries. Begin with most recent and work backwards):

1. Past Conditions	Date of Onset	Type of Treatment	Continuing Effects (if any)

2. Current Medications (prescribed and non-prescribed):

Type	Strength	Dosage	Side Effects	Benefits/Compliance

3. Past Medications (no longer using)

Type	Strength	Dosage	Side Effects	Benefits/Compliance

4. Are there any family members with chronic medical conditions (type of illness and relationship to family member):

5. Within the past 30 days, has your child experienced any significant physical symptoms?
(Convulsions; Persistent Pain; Severe headache with blurred vision; Unusual Bleeding; Head Injury; Bruises; etc.)

❑ Yes ❑ No If yes, how many days in the last 30? _____ Please explain:

6. Does your child have any chronic medical problems which continue to interfere with his/her life? ❑ Yes ❑ No

7. Does your child receive any financial assistance a physical disability? ❑ Yes ❑ No If yes, specify:_____

8. Does your child have any allergies (food, medications, chemicals, vapors)? ❑ Yes ❑ No If yes, list allergies:

9. Who is your child's Primary Care Physician: _____ Phone: _____

When was the last time she/he had a medical checkup with your primary care physician?_____

10. Is your child currently involved in any behaviors that risk compromising safety and/or health? ❑Yes ❑No
If yes, explain:

11. **During the past 90 days** have there been medical/physical health issues that are related to your child's presenting problems and need to be a focus of your treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

Behavioral Health History

1. Is your child currently receiving any mental health or substance abuse services from any other treatment provider? ❑Yes ❑No If Yes, where:

2. Has your child had a significant period in which she/he has experienced:

Serious depression: ❑Yes ❑No Serious anxiety or worry: ❑Yes ❑No Seeing/hearing things not there: ❑Yes ❑No
Trouble controlling violent behavior: ❑Yes ❑No Trouble understanding, concentrating, or remembering: ❑Yes ❑No
Cutting or other self-harm: ❑Yes ❑No Lying to people: ❑Yes ❑No Feeling detached from place/time: ❑Yes ❑No
Spending more time on the internet than with people: ❑Yes ❑No Other:_____

3. How many days in the past 30 days has your child experienced any psychological or emotional problems?:_____

4. Has your child had previous behavioral/psychiatric treatment: ❑Yes ❑No If Yes:

1. Where:_____ Diagnosis:_____

Dates of Service:_____

Why did you seek the services:_____

What were the results:_____

2. Where: _____ Diagnosis: _____

Dates of Service:_____

Why did you seek the services:_____

What were the results:_____

5. Have close family members received treatment for mental health or substance abuse? ❑Yes ❑No If yes, please explain:

6. Has your child been engaging in any substance abuse or other behaviors that have the potential to become habitual or addictive? ❑Yes ❑No If yes, please explain: _____

13. **During the past 90 days** have there been any mental health, substance use, or other harmful or addictive behaviors that are related to your child's presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

DEVELOPMENTAL/CHILDHOOD HISTORY

1. Does your child have difficulty remembering any periods of time during his/her earlier childhood? ❑Yes ❑No

2. Where did your child live and who lived in your child's household during his/her earlier childhood?

3. How would you describe your child while growing up? (read the list and check all that apply):

❑ Popular ❑ Rebellious ❑ Unhappy ❑ Serious ❑ Calm ❑ Awkward
❑ Happy ❑ Unpopular ❑ Shy/quiet ❑ Aggressive ❑ Nervous

4. Has your child experienced any of the following problems while growing up? (read the list and check all that apply):

❑ Conflict with mother ❑ Conflict with father ❑ Conflict with caretaker ❑ Conflict with siblings
❑ Conflict with peers ❑ Conflict with teachers ❑ Nightmares ❑ Bed-wetting
❑ Overweight ❑ Underweight ❑ Excessive worries/fears ❑ Drug/alcohol use
❑ Frequent arguing ❑ Financial problems ❑ Cutting or burning ❑ Bullying/being bullied

5. What is the quality of your child's current relationships with family members?:

Father, mother, brothers, or sisters (or other close family)	Age	Explain the quality of current relationship:	Frequency of contact:

6. **During the past 90 days** have there been issues regarding your child's childhood development that are related to the presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

SEXUALITY

1. Has your child had any sexual experiences that would not be considered age-appropriate? ❑Yes ❑No If yes, what are they?

2. Has your child displayed any behaviors that would suggest some confusion about his/her sexual identity as a male or female? ☐Yes ☐No If yes, please explain:

3. **During the past 90 days** has your child experienced issues regarding his/her sexuality that are related to the presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

ABUSE/TRAUMA HISTORY

<u>Adverse Childhood Experiences (ACE):</u> While growing up, has you child experienced:

1. Did a parent or other adult in the household **often or very often…**
   Swear at, insult, put down, or humiliate your child?
   OR
   Act in a way that made your child afraid of being physically hurt? ❑Yes ❑No If YES enter 1_____
2. Did a parent or other adult in the household **often or very often…**
   Push, grab, slap, or throw something at your child?
   OR
   Ever hit your child so hard to leave marks or cause injury? ❑Yes ❑No If YES enter 1_____
3. Did an adult or person at least 5 years older than your child **ever…**
   Touch or fondle your child or have your child touch their body in a sexual way?
   OR
   Attempt to actually have oral, anal, or vaginal intercourse with your child? ❑Yes ❑No If YES enter 1_____
4. Did your child **often or very often** feel that…
   No one in your family loved your child or thought your child were important or special?
   OR
   Your family didn't look out for each other, feel close to each other, or support each other?
   ❑Yes ❑No If YES enter 1_____

5. Did your child **often or very often** feel that…
   Your child didn't have enough to eat, had to wear dirty clothes, and had no one to protect him/her?
   OR
   The parents were too drunk or high to take care of your child or take your child to the doctor if it were needed? ❑Yes ❑No If YES enter 1_____
6. Were your child's parents **ever** separated or divorced? ❑Yes ❑No If YES enter 1_____
7. Was your child's mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   OR
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   OR
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife? ❑Yes ❑No If YES enter 1_____
8. Did your child live with anyone who was a problem drinker or alcoholic or who used street drugs? ❑Yes ❑No If YES enter 1_____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? ❑Yes ❑No If YES enter 1_____
10. Did a household member go to prison? ❑Yes ❑No If YES enter 1_____

Now add up your "YES" answers to get your ACE Score_____

11. What is the worst thing that has ever happened to your child?

12. Has your child ever experienced or witnessed an event in which she/he were seriously injured or his/her life was in danger, or thought she/he were going to be seriously injured or endangered? If yes, please explain:

13. Has your child ever been the victim, a perpetrator, or been exposed in any way to……? (check all that apply)

Physical Abuse:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Domestic Violence:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Community Violence:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Physical Neglect:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Emotional Abuse:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Elder Abuse:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current
Sexual Abuse:	❑ Victim	❑ Perpetrator	❑ Direct exposure	❑ Indirect exposure	❑ Current

If victim, perpetrator, or type of exposure were checked to any of the above, please explain below:

1. Type:_____ Age it occurred:_____

   Length (single event, several events, ongoing/number of years):_____

   _____

   Other person(s) involved: _____

Current relationship, if any, with person(s) involved: _____

Treatment, if any, and outcome of treatment: _____

2. Type:_____ Age it occurred:_____

Length (single event, several events, ongoing/number of years):_____

_____

Other person(s) involved: _____

Current relationship, if any, with person(s) involved: _____

Treatment, if any, and outcome of treatment: _____

3. Type:_____ Age it occurred:_____

Length (single event, several events, ongoing/number of years):_____

_____

Other person(s) involved: _____

Current relationship, if any, with person(s) involved: _____

Treatment, if any, and outcome of treatment: _____

14. **During the past 90 days** do you believe issues regarding any past or current abuse or trauma are related to your child's presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

EDUCATION

1. What was the highest grade your child completed (circle) Elementary K 1 2 3 4 5 6 7 8 9

2. How would you rate your child's performance in school: ❑Above average ❑Average ❑Below average

3. Has your child experienced any problems in school? ❑Yes ❑No If yes, explain:_____

_____

4. Does your child have any learning, hearing, of seeing disabilities that would prevent him/her from reading, writing, or understanding English and would be a barrier to full participation in treatment? ❑Yes ❑No If YES, are there assistive technologies that would help to overcome this barrier:
❑Yes ❑No If YES, please explain:_____

5. **During the past 90 days** do you believe issues regarding your child's education and learning abilities are related to the presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

LEGAL HISTORY

1. Has your child been involved in juvenile delinquent or illegal activities?: ❑Yes ❑No If YES, please explain:

2. Is your child currently on probation or under court supervision?: ❑Yes ❑No If YES, please explain:

3. **During the past 90 days** have there been issues in your child's current or historical legal experiences that are related to the presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

ETHNIC/CULTURAL ORIENTATION

1. How would you categorize your child's ethnic/cultural orientation (size of community raised in; political beliefs; religious observation; racial minority; social economic status; value of education): Please explain:

2. Did your child's family practice traditions and rituals associated with past family or religious history? ❑Yes ❑No

If yes, what traditions and rituals:_____

If yes, was there a sense of pride in participating in those traditions and rituals? ❑Yes ❑No

3. Are there any cultural practices linked to your child's racial/ethnic background that are important to him/her? ❑Yes ❑No If yes, explain:

4. **During the past 90 days** have there been issues in your child's ethnic or cultural orientation that are related to the presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

LEISURE/RECREATIONAL

1. What are your child's usual free time activities? a. _____ b. _____ c. _____

2. What are your child's hobbies? a. _____ b. _____ c. _____

3. How much free time does your child have in a week? ❑1-5 hours ❑ 5- 10 hours ❑ 10+ hours

4. **During the past 90 days** have there been issues in your child's leisure/recreational pursuits that are related to the presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

SPIRITUALITY

1. Is your child involved in a church or a religion? ❑Yes ❑No

2. If yes, with what faith does your child identify with: _____

3. Does your child believe that there is a "higher power" or a "God"? ❑Yes ❑No

4. What activities does your child engage in spiritually (read list and check those that apply):
❑ Prayer ❑ Meditation ❑ Church attendance ❑ Active participation in church activities ❑ Sweat Lodge
❑ Pilgrimages to religious sites or events ❑ Reading spiritual materials ❑ Other: _____

5. Is your child bothered by guilt or shame for past events that he/she believes are wrong or against his/her spiritual beliefs? ❑Yes ❑No If yes, explain:

6. **During the past 90 days** have there been issues in your child's spirituality that are related to the presenting problems and need to be a focus of treatment? ❑Yes ❑No If yes, what are these and how motivated is your child to address these in counseling? Please explain:

(This section is completed by a clinician)

DAILY LIVING ACTIVITIES

1. Using the table below, rate how often or how well the youth independently, as age-appropriate, performed each of the 20 Activities of Daily Living during the last 30 days. If the consumer's level of functioning is varied, rate the lower score. Consider impairments in functioning due to physical limitations as well as those due to mental impairments. Do not consider environmental limitations (eg. "no appropriate school or jobs available").

   Strengths are scored >=5 in an activity and indicates functioning "within normal limits (WNL) for that activity.

1	2	3	4	5 (WNL)	6 (WNL)	7 (WNL)
None of the time. Pervasive, continuous intervention required. Dysfunctional. **Disabling impairment**.	**Almost never**. Not functional. Dependent. **Severe impairment**.	**Occasionally**. Functioning depends on continuous support. **Substantial impairment**.	**Some of the time.** Marginal independence. Low level of continuous support. **Serious impairment.**	**A good bit of the time.** Independent with moderate, routine support. **Moderate problems.**	**Most of the time.** Independent with intermittent support or follow-up. **Intermittent problems**.	**All of the time**. Optimal and independent asset. **No problems**.

Activities	Example of scoring strengths as WNL behaviors (scores 5-7)	Score
1. Health Practices	Assist or manage adequate weight, moods, outdoor exercise, aches, pains. Take medications or over the counter drugs with adult supervision only.	
2. Housing Stability, Maintenance	Housing is stable and youth contributes to stability in the home (age-appropriate). Respect others and property. Share in chores, involve caretakers in school related projects, grades.	
3. Communication	Greets adults. Listens. Expresses feeling, anger, opinions effectively.	
4. Safety	Play it safe? Avoid guns, knives, matches, danger people or places where there is likely trouble or an abuse potential. If driving, has a safe record.	
5. Managing Time	Assist or manage time for promptness. Regularly attends school and work (age appropriate). Routinely completes tasks. Sleep, wake, meals on regular basis?	
6. Managing Money	Reliably handles or manages monetary allowance. Abstains from overspending personal limits. Betting, stealing, borrowing?	
7. Nutrition	Eats at least 2 basically nutritious meals with caretakers. Eat healthy snacks that reasonably limit sugar and caffeine?	
8. Problem Solving	Understand presenting problems, reasons for seeking services. Focus on possible solutions for age-appropriate time periods. Assist or manage difficult situations?	
9. Family Relationships	Feel close to at least one other person at home. Get along with family or caretakers. Feel loved?	
10. Alcohol/Drug Use	Abstain from smoking cigarettes, drinking alcohol, doing drugs or inhalants of any kind. Avoid high risk drinking situations and people who do drugs?	

11. Leisure	Enjoy two or more fun and relaxing activities: musical instruments, music, watching/playing sports, reading, computer or board games, cards, art, hobbies, movies, TV?	
12. Community Resources	Use community activities, resources such as after-school sponsored tutoring, clubs, sports, scouts, Boys/Girls Clubs, library, church, dances?	
13. Social Network	Make and keep same-age friends. Avoid bullying, gangs, cults, anti-social groups.	
14. Sexuality	Reports age-appropriate sexually responsible behaviors with girls/boys. Educated and avoids sexual activities, infections, pregnancy?	
15. Productivity	Feel good about performance at school. Consider grades to be good. Complete school projects without undue difficulty. Have vocational goals?	
16. Coping Skills	Accept adult correction without undue arguing, temper outburst. Tolerates frustration.	
17. Behavior Norms	Control threatening or physical expression of anger, violent behavior - either to self or others or property. Law abiding, responsible with school, community rules, driving car.	
18. Personal Hygiene	Help or manage general cleanliness - daily shower/bath, brush teeth.	
19. Grooming	Assist or manage general appearance: hair, shave, comply with school rules	
20. Dress	Assist or responsibly care for clean clothes, comply with school dress code.	
Scoring Instructions: Ratings for all 20 DLA's can be added and then divided in half to estimate the GAF score.	Sum (max. 140)	
	GAF Score	

2. What are the most important things in the client's life that provide meaning, purpose, and makes life worth living?:

3. What are the prioritized problems that interfere the most with the client's life worth living goals? **Summarize the client's problems/needs and corresponding goals/expectations of treatment services.**

Priority #	Problems/Needs	Goals/Expectations

4. Summarize the behavioral health problems/**issues that the agency can realistically assist the client in resolving; what type of services/treatment are needed; what is the estimated length/intensity of treatment:**

5. What **additional services and/or referrals** (to other community agencies) will the client need in order to improve their quality of life and/or to facilitate recovery?:

Assessment Completed by: _____ Credentials _____

Date:_____