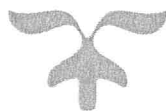


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**CONFIDENTIAL**

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Name: \_\_\_\_\_



Child Inventory

**Child Inventory**

**Please read and answer the following questions. Information provided will be discussed during the initial meeting with the therapist.**

**Presenting Information**

What are your primary concerns?

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When did these concerns first start? \_\_\_\_\_

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How have they or the family members been trying to cope/manage with these concerns?

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What changes, stresses, or losses have occurred in the past 1-2 years?

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**Mental/Emotional Health History**

Have they ever received counseling of any type?  Yes  No

Have they had services with this agency prior to this date?  Yes  No

Have they been hospitalized for mental health or drug/alcohol treatment?  Yes  No

If yes, please explain and provide dates:

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Past providers and dates of services:

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Has anyone in the family been diagnosed with mental health or emotional illness?  Yes  No

If yes, explain:

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**Symptoms Checklist**

Please rate each symptom below using the scale provided. (No Concerns=0, 1, 2, 3, 4, 5= Major Concern)

Depressed \_\_ Sleep Disturbance \_\_ Anxiety/Agitation \_\_ Obsessions \_\_ Paranoia \_\_

Suicidal Ideations \_\_ Substance Abuse \_\_

Have they ever experienced thoughts of suicide? \_\_Yes \_\_No

In the past 2 weeks have they thought of suicide? \_\_Yes \_\_No

Have they ever attempted suicide? \_\_Yes \_\_No

**Medical History**

Who is they Primary Care Doctor?

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Place of Practice?

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Do they take any medications? \_\_ Yes \_\_ No

<u>Medication</u>	<u>Dosage:</u>	<u>Treating:</u>

**Please list any chronic illness, disabilities, medical conditions that they have been diagnosed with:**

<u>Illness/Disability</u>	<u>Dates:</u>

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Has your child ever experienced any type of abuse (physical, sexual, or emotional)? If yes, please explain.

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Have they child ever made a statement of wanting to hurt him/herself or seriously hurt someone yes? If yes, please explain.

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Have they child purposely hurt someone or him/herself?  Yes  No

If yes, please explain.

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Have they child experienced any serious emotional losses (such as death of or physical separation from a parent or caretaker)?  Yes  No

If yes, please explain.

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Please list any major life transitions or concerns.

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Does your family have any current or history of court involvement with DHHS?

If yes, please explain. \_\_\_\_\_

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Family History

Mothers Name: \_\_\_\_\_ Fathers Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Name:	Age:	Relationship:	Grade/Job:

Who are you child's significant others NOT living in the same house?

Name:	Age:	Relationship:	Grade/Job:

Describe your child's relationship with their family siblings?

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Who is your child closest to?

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What are some strengths as a family?

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Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets them in trouble? If yes, please explain.

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Are there any behaviors that your child fails to do as often as you would like or when you would like?

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How do you describe your child's self-esteem?

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What goals would you like to accomplish during the therapy process as a parent?

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Does your child have different goals they would like to accomplish? (If they are the same, you can skip this one.)

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Is there anything else that you think would be important for me to know about your child or your family? \_\_\_\_\_

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**Social History**

Do they have friends?    \_\_Yes        \_\_No

How many close friends do they have?    1        2        3        4        5 or more

List leisure/recreational activities:

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List their strengths: \_\_\_\_\_

List their weaknesses: \_\_\_\_\_

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**Developmental History**

Were they exposed to drugs or alcohol before birth or early childhood? If yes, please explain. \_\_\_\_\_

Are there any identified delays in development?

Speech Functioning  Yes  No

Hearing Functioning  Yes  No

Visual Functioning  Yes  No

Walking  Yes  No

Other Abilities  Yes  No

Have they had any serious injuries or accidents, specifically involving head injury? If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

