Nimkee Nupigawagan

Healing Centre

PRE-ASSESSMENT

(Please complete in Ink)

Participant

1. Participant Name_____Sex_____Age_____DOB_____
2. Natural Child Yes / No If adopted, at what age_____Foster since _____
3. Parent's Names (include step-parents, foster parents, inc.)

   _____

   _____
4. Comments about custody and visitation (if applicable):

   _____

   _____
5. Primary reason for attending treatment?

   _____

   _____

   _____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a.
- _____ Sleep problems
- _____ Lack of interest in activities
- _____ Unassertive
- _____ Fatigue/low energy
- _____ Concentration problems
- _____ Appetite/weight changes
- _____ Withdrawal
- _____ Morbid thoughts
- _____ Suicidal thoughts or threats
- _____ Suicidal plans / attempts
- _____ Mood swings
- _____ Depression
- _____ Changed level of activity
- _____ Cries easily

b.
_____ Forgetful/memory problems
_____ Short attention span
_____ Aggressive behavior
_____ Can't sit still
_____ Not interested in peers
_____ Picked on / bullied by peers
_____ Talks excessively / interrupts
_____ Easily distracted
_____ Irritable
_____ Impulsive
_____ Difficulty following rules
_____ Problem completing schoolwork

Excessive worry / fearfulness	Nightmares
Anxiety or panic attacks	Frequent tantrums
Social fears, shyness	Resistive to change
Separation problems	School refusal
Bedwetting / soiling	Perfectionism
Headaches, stomachaches	Odd hand / motor movements
Odd beliefs / fantasizing	Hallucinations
Lying	Stealing
Trouble with the law	Being destructive
Running away	Fire setting
Truancy, skipping school	Hurting others / fighting
Hurting others sexually	Acts as if has no fear
Alcohol / drug use	Short tempered
Argumentative / defiant	Easily annoyed / annoys others
Swears	Discipline problem
Blames others for mistakes	Angry and resentful

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

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SCHOOL HISTORY

1. Present School:_____Grade:_____Teacher:_____
2. Has youth ever repeated any grade? _____
3. Is youth in special education services? No_____Yes, what kind? _____
4. Please describe academic or other problems your child has had in school

_____

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1. **Developmental History**

- State approximate age when child did the following:

Walked alone_____Said first word_____Used 2-word phrases _____

- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did child cry excessively?_____Rarely cried _____

2. **Health History of Child**

In the first two years, did your child experience:____Separation from mother,

__Out of home care,___Disruption in bonding,__Depression of mother, _Abuse,

___Neglect,___Chronic pain,___Chronic Illness, _Parental Stress

- Child's Doctor: _____
- Date of last physical exam: _____
- Vision problems? Yes _____ ***No_____*** ***Hearing problems? Yes ____*** ***No _____***
- Dental problems? Yes_____No _____
- Any head injuries or loss of consciousness? Yes _____ ***No _____***
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No_____ ***Yes – describe and give dates. _____***

- Is your child currently taking any medications? No_____Yes_____name medications

_____

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- List any medicines previously used for emotional problems: were they helpful? _____

  _____

- Allergies to drugs or medicines? No_____Yes_____(list) _____
- Allergies to any foods? No_____Yes_____(list) _____
- Are there any foods that you limit or do not give this child? No_____Yes _____

  (list)_____.
- Allergies to environmental conditions? No_____Yes_____(list) _____
- Does anyone in the household smoke? No_____Yes _____
- About how many hours does this child watch TV, videos, etc per day _____
- Are you afraid someone you know may injure/harm this child? No_____Yes _____
- Does this child have a Health Care Directive? No_____Yes _____

  If yes, please list where (clinic) it is on file. _____
- Any previous psychological or psychiatric treatment? No_____Yes _____

  Whom/where_____when_____
- Any previous testing (school/psychological)? No_____Yes _____

  Whom/where_____when_____
- Do you think your use of chemicals is a problem? No_____Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs _____

Family History:

Chemical use (now & past): No____Yes_____
Which parent(s) _____

Type: Alcohol _____ Marijuana _____ Other drugs_____

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List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____

_____

Has child witnessed domestic violence?__Y,_____N,
Specify: _____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

LIFE STRESSORS/TRAUMA HISTORY

1. Have you ever been verbally abused? Y,____N,__suspected___ Specify: _____

_____

2. Have you ever been physically abused? Y,____N, ____ suspected ___Specify: _____

_____

3. Have you ever been sexually abused Y,___N,_____suspected ___Specify: _____

_____

4. Other stressors or traumas?_____

_____

What are your strengths?

Any additional comments or information that would be helpful for you in your healing?

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