

EDUCATIONAL PLANNING AND COUNSELING SERVICES

MENTAL HEALTH ASSESSMENT FOR CHILDREN AND YOUNG ADULTS AGES 5 AND ABOVE

THANK YOU FOR TAKING THE TIME TO COMPLETE OUR ASSESSMENT

CHILD'S FULL NAME: _____

AGE _____ GENDER _____ MALE _____ FEMALE

GRADE COMPLETED: _____ DISABILITY _____

IMPAIRMENT _____

CURRENT DIAGNOSIS:

MY CHILD HAS A DEVELOPMENTAL DISABILITY ____ YES ____ NO

MY CHILD HAS PROBLEMS IN THE FOLLOWING BEHAVIORAL AREAS:

_____ BEHAVIORAL CHALLENGES _____ ACTING OUT. FIGHTING, SCREAMING, YELLING, AND UNABLE TO CONTROL EMOTIONS. THROWING TANTRUMS _____ ARGUING WITH SIBLINGS, AND PARENTS ETC.

CHILD HAS BEEN HAVING

_____ MULTIPLE HOSPITALIZATION

_____ ONGOING PSYCHIATRIC PROBLEMS: (PLEASE DESCRIBE)

_____ NOT TAKING MEDICATION OR RELAPSES CAUSING NEED FOR HOSPITALIZATION OR TREATMENT PLACEMENT

_____ THREATENING HARM TO SELF OR OTHERS

DESCRIBE _____

MY RESPONSE HAS BEEN _____

WHERE WAS YOUR CHILD TREATED: (HOSPITAL OR PROGRAM?) _____

WHO WAS THE PHYSICIAN? _____

HOW LONG HAVE THEY BEEN TREATED BY A
PSYCHIATRIST _____

DESCRIBE THE NATURE OF THEIR TREATMENT

ARE THEY LIVING AT HOME NOW ____ YES ____ NO IF NO, WHERE ARE THEY LIVING?

ADDRESS OR CONTACT INFORMATION WHERE THEY CURRENT LIVE:

ARE THEY IN FOSTER CARE OR A GROUP HOME ____ YES ____ NO

HOW LONG HAVE THEY BEEN LIVING THERE _____

HAVE THEY EVER WORKED _____ HOW LONG _____

WHAT CHALLENGES HAVE THEY HAD

WOULD YOU SAY THEIR CONDITION HAS CHANGED OR GOTTEN WORSE?

ARE THEY RECEIVING SOCIAL SECURITY BENEFITS ____ YES ____ NO _____

AMOUNT CHILD OR ADULT RECEIVED _____ *SS/SSDI*

DATE RECEIPT _____

WHO MANAGES THIS YOUNG ADULT'S FINANCES _____ PARENTS _____ RELATIVE _____
OTHER GUARDIAN _____

ARE YOU THE LEGAL GUARDIAN _____ YES _____ NO?

DESCRIBE:

WHAT SUPPORT SYSTEM IS IN PLACE FOR THIS CHILD OR YOUNG ADULT? (CHECK ALL THAT APPLY)

_____ FAMILY _____ FRIENDS: DESCRIBE IN MORE DETAIL _____

CHURCH FAMILY _____ NEIGHBORS _____

FAMILY OUTSIDE THE COUNTRY _____ PEERS _____

CITY/STATE/COUNTRY _____ CITIZENSHIP _____

CURRENT GRADES ARE ___ EXCELLENT ___ AVERAGE ___ GOOD ___ POOR ___ FAILING

DOES THE CHILD OR YOUNG ADULT ATTEND SCHOOL? STATUS: FULL TIME: ___

STATUS: FRESHMAN _____ SOPHOMORE _____ JUNIOR _____ SECONDARY
SCHOOLS OR MIDDLE SCHOOL _____ ELEMENTARY

SENIOR _____ GRADUATE STUDENT _____

PART TIME _____ PART TIME _____ FULLTIME _____

SCHOOL OR COLLEGE _____

CITY STATE _____

BRIEFLY DESCRIBE: THE MOST RECENT BEHAVIOR OF THE CHILD?

BRIEFLY DESCRIBE: WHETHER THEY ARE ON MEDICATION OR RECEIVE MEDICAL ATTENTION? DO THEY HAVE A PRIMARY DIAGNOSIS AND PHYSICIAN WHO? NAME AND ADDRESS PLEASE!

DESCRIBE: _____

HOW LONG HAS THIS CHILD ADULT HAVING PROBLEMS? WHEN WERE THEY HOSPITALIZED?

HAS THE CHILD OR YOUNG ADULT EVER ATTEMPTED SUICIDE OR CAUSED DANGER TO OTHERS DESCRIBE:

ARE THERE ANY CONFLICTS AT HOME WHICH MIGHT HAVE CAUSED THIS PROBLEM?

_____YES OR NO

DESCRIBE _____

HOW LONG HAVE THESE PROBLEMS EXISTED _____MONTHS _____YEARS

ARE YOU THE LEGAL GUARDIAN _____YES _____NO

WHO IS THE GUARDIAN _____

DESCRIBE IN DETAIL WHAT STEPS YOU HAVE TAKEN TO ENCOURAGE INDEPENDENT LIVING:

BRIEFLY: TELL US WHAT HAPPEN?

WHAT CONCERNS DO YOU HAVE SINCE THEIR LAST HOSPITALIZATION?

BRIEFLY DESCRIBE THEIR MOST RECENT EPISODE?

WHO HAD TO INTERVENE?

___THERAPIST ___LOCAL POLICE ___TRANSPORT COMPANY ___
FAMILY AND FRIEND ___ NEIGHBORS ___ OTHER PROFESSIONALS
___TYPE OF PROFESSIONAL___

HOW WOULD YOU DESCRIBE THE CURRENT CONDITION WITH YOUR CHILD?

SEVERE IMPAIRMENT ___MODERATELY IMPAIRED___ MILDLY IMPAIRED ___
___UNMANAGEABLE

DESCRIBE THEIR PHYSICAL HEALTH:

WAS THE DISABILITY IDENTIFIED BY THE HOSPITAL? MENTAL ILLNESS _____

OTHER IMPAIRMENT_____

COGNITIVELY IMPAIRED_____ PHYSICAL IMPAIRED_____ MENTAL IMPAIRMENT
___SENSORY IMPAIRED _____ OTHER IMPAIRMENT:

DESCRIBE: _____

ARE YOU RECEIVING ANY ACCOMMODATIONS TO ADDRESS THIS PROBLEM? THROUGH A
STATE OR LOCAL AGENCY (HEALTH CARE OR SOCIAL SERVICES ___YES ___NO

WHAT SERVICES_____

IS THE ADULT LEGALLY EMANCIPATED ___YES ___NO

DO THEY HAVE ANOTHER IMPAIRMENT ___YES ___NO (VISION? HEARING, MOTOR
COORDINATION

DESCRIBE_____

HAS YOUR CHILD EVER RECEIVED MENTAL HEALTH SERVICES? WHERE, AND WHEN?

HAS YOUR CHILD EVER BEEN ADMITTED INTO A RESIDENTIAL TREATMENT FACILITY?

YES _____ NO _____ DATE _____ YEAR?

WHAT DO YOU BELIEVE WERE THE CHALLENGES OVERLOOKED BY ANY OF THE AGENCIES OR MEDICAL STAFF?

HOW HAVE YOU BEEN HANDLING THESE CHALLENGES?

DO YOU BELIEVE THERE IS A NEED FOR AN ADDITIONAL MEDICAL OR MENTAL HEALTH PROFESSIONAL OR SERVICES?

WOULD YOU CONSIDER THE ADVICE OF ANOTHER PROFESSION REGARDING LONG TERM PLACEMENT?

WOULD COST BE A DETERMINING FACTOR _____ YES _____ NO _____ MAYBE _____ PERHAPS?

EXPLAIN: _____

HAVE YOU DISCUSSED YOUR CONCERNS WITH YOUR CHILD OR YOUNG ADULT?

WHAT HAS BEEN THEIR RESPONSE?

PLEASE FAX OR SEND TO US VIA EMAIL THE ANY TRANSCRIPTS OR SCHOOL RECORDS TO OUR EMAIL, WHICH IS INFO@EDUCATIONAL-PLANNING-AND-COUNSELING.ORG

WHAT IS YOUR CHILD OR YOUNG ADULT'S INTELLECTUAL QUOTIENT? IQ _____ ?

WHAT WERE THE RESULTS: (IF NOT TAKEN PUT NONE)

SCORES: _____

RESULTS: _____

____YES ____NO

HOW WOULD YOU DESCRIBE YOUR KNOWLEDGE OF THE LEGAL PROCESS IN ADDRESSING YOUR CHILD'S OR YOUNG ADULTS' NEEDS?

WOULD YOU SAY YOU AWARE OF THE FOLLOWING?

ISSUES OF THE IEP _____ KNOWLEDGE OF IDEA _____ KNOWLEDGE AMERICAN DISABILITIES EDUCATION ACT _____ HEALTH INSURANCE PORTABILITY ACT AS IT APPLIES TO INFORMATION _____

HOW WOULD YOU DESCRIBE YOUR CHILD'S NEEDS SINCE HIS/HER ANTICIPATED PLACEMENT?

NEEDS HAVE BEEN ADDRESSED _____ NOT ADDRESSED _____ NEED MORE INFORMATION _____

TO YOUR KNOWLEDGE HAS YOUR CHILD EVER USE OR EXPERIMENTED WITH DRUGS

____YES ____NO

EXPLAIN IN DETAIL:

HAS THERE BEEN ANY RELAPSE OR USE OF DRUGS RECENTLY

IF THE ADULT DOES NOT HAVE ANY SUBSTANCE ABUSE ISSUES, ARE THERE ANY MENTAL HEALTH ISSUE NOT MENTIONED:

DESCRIBE _____

EXPLAIN:

HAS YOUR CHILD EVER EXPERIENCED ANY TRAUMA OR EVENT WHICH HAS CAUSED YOU CONCERN? (LOSS OF FAMILY MEMBER, MOVED, CHANGE IN SCHOOLS)

DATE OF THE EVENT: _____ YEAR _____

HAS YOUR CHILD ENGAGED IN SELF DESTRUCTIVE BEHAVIOR? (PARANOID THINKING, SUSPICIOUS BEHAVIOR LYING, THREATENING OTHERS, RUNNING AWAY)?

DESCRIBE YOUR CHILD'S LEVEL OF CONFIDENCE OR SELF ESTEEM?

DOES YOUR CHILD HAVE ANY LEARNING DIFFERENCES

DESCRIBE: _____

DOES YOUR CHILD HAVE AUTISM _____ YES _____ ON THE SPECTRUM HOW SEVERE IS THE CONDITION.

_____ VERY SEVERE _____ MODERATE _____ SOMEWHAT SEVERE _____ VERY SEVERE

IS YOUR CHILD TAKING ANY MEDICATION OR RECEIVING MEDICAL ATTENTION?

WHAT IS THE NATURE OF THEIR CONDITION? (AGITATED, RESTLESS, NOT SLEEPING, AND NOT EATING)

HOW LONG HAVE THEY BEEN IN THIS CONDITION? WHAT CARE WAS RECEIVED? WHERE?

WHO WAS THE DOCTOR: _____

MAY WE CONTACT THEM?

YES _____ NO _____

ADDRESS

CITY/STATE/COUNTRY

WOULD YOU DESCRIBE YOUR CHILD'S OVERALL HEALTH AS?

_____ EXCELLENT _____ GOOD _____ NOT SO GOOD _____ VERY POOR

WHERE WOULD YOU BE MOST COMFORTABLE IN PLACING YOU CHILD AFTER LEAVING A THERAPEUTIC OR WILDERNESS?

_____PUBLIC SCHOOL _____PRIVATE SCHOOL_____ BOARDING SCHOOL
_____CHARTER SCHOOL _____VOCATIONAL SCHOOL _____COLLEGE

AGREEMENT

BY GIVING CONSENT THE PARENT SIMPLY AGREES TO ALLOW THE EDUCATIONAL CONSULTANT TO WORK ON BEHALF OF THE FAMILY IN A PLACEMENT OR SCHOOL OR PROGRAM.

PARENT SIGNATURE

FULL NAME/PLEASE PRINT

ARE YOU THE LEGAL GUARDIAN OR PARENT _____YES _____NO?

WHO IS THE LEGAL GUARDIAN _____?

DO YOU HAVE JOINT CUSTODY? _____

ADDRESS

CITY/STATE/COUNTRY/

KENNETH DAVIS MA ED EDUCATIONAL CONSULTANT

DATE/MONTH/YEAR COMPLETED ASSESSMENT

PLEASE FAX THE FORM TO OUR FAX: 623 322-9481