NHC ASSESMENT and HISTORY INFORMATION - Child

Child's Name: _____ Date: _____

□ YES □ NO Has child ever been treated by a psychiatrist?

□ YES □ NO Has child ever been treated by a counselor/therapist?

If yes, who did you see? _____

Child's Physician: _____

Last time seen by physician: _____

Reason for visit: _____

Is child on medication? Y N If yes, what medication(s)_____

_____._____

□ YES □ NO Has child been diagnosed with developmental problems?

□ YES □ NO Any speech impairment problems?

□ YES □ NO Has child been exposed to trauma?

□ YES □ NO Any mental health problems on fathers/mothers family?

If yes, please indicate who and what diagnosis?_____

□ YES □ NO Any complications during pregnancy?

□ YES □ NO Any complications at birth?

Briefly describe your reasons for seeking counseling services: _____

_____

What kind of things have you tried so far to handle this situation?: _____

_____

Please place a number that best corresponds to the issue listed below:

NOT APPLICABLE		NOT VERY SERIOUS		SERIOUS		VERY SERIOUS
1	2	3	4	5	6	7

____Abuse – Physical	____Abuse – sexual	____Abuse – emotional
____Abuse – neglect	____Aggression, violence	____Anger, hostility, irritable
____Anxiety, nervousness	____Attention, distraction	____Confusion
____Compulsions	____Cruelty to animals	____Crying, sadness
____Decision-making, indecision	____Delusions (false ideas)	____Depression
____Divorce, separation	____Eating problems	____Grieving
____Guilt	____Headaches	____Impulsiveness
____Judgment	____Loss of control	____Memory problems
____Mood swings	____Obsession/compulsion	____Panic/Anxiety attacks
____School problems	____Self-esteem	____Sleep problems
____Stress	____Suicidal thoughts	____Temper/low tolerance
____Thought disorganization	____Bed wetting	

Other: _____

In the past 36 months has there been a death of a family member or someone close to child?

□ YES □ NO If yes, who?:_____ When: _____

Prior to the 36 months, has there been a death of someone that was close to child?

□ YES □ NO If yes, who?:_____ When: _____

Please rate below on a scale of 1 though 10, 1 = not at all, and a 10 = very much so:

_____ Child is very close and has a good relationship with siblings.

_____ Child has several close friends.

_____ Child often has nightmares.

_____ Child prefers to spend time alone.

_____ Child does not make eye contact when spoken to.

_____ Child does not like being around other people.

_____ Child likes self.