**Child and Adolescent Diagnostic Assessment Worksheet**

**IDENTIFYING INFORMATION: (age, gender, and ethnicity of client; parents)**

**COLLATORAL INFORMANTS**:

**CHIEF COMPLAINT: (in the client’s own words**)

Other informants:

**HISTORY OF PRESENT ILLNESS**: **(this should create the timeline and details of the child/adolescent symptoms so that it leads to the clinical assessment and formulation)** ­­­­­­­­­­­­

**PAST PSYCHIATRIC HISTORY/PREVIOUS PSYCHIATRIC VISITS/HOSPITALIZATIONS:­­­­­­­­­­**

**PAST MEDICAL HISTORY**:

**PAST SURGICAL HISTORY**:

**CURRENT MEDICATIONS (INCLUDING COMPLIANCE):**

**ALLERGIES**:

**PSYCHOSOCIAL** **HISTORY: (who the child lives with, relevant cultural information, school, grade, teacher, friends)**

Sexual Orientation/Gender Identity (if unknown, evidence of gender dysphoria):

­­­­­­­­­­­­­­­­­­(NOTE: If LGBT, elicit “out” status, family dynamics): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of physical/emotional/sexual abuse: \_\_\_\_\_\_\_\_\_\_ History of bullying: \_\_\_\_\_\_\_\_\_Religion: \_\_\_\_\_\_\_\_

**FAMILY HISTORY OF PSYCHIATRIC ILLNESS:**

History of Family Suicide Attempts/Completed Suicides:

**SUBSTANCE ABUSE HISTORY:**

Smoker: \_\_\_\_\_History of alcohol, marijuana, meth use/abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYMPTOMS:**

**GENERAL WELL BEING:**

**(Example:**

**-Child/parent reports that (she/he) is sleeping (well, poorly, fair). States that (she/he) has trouble (falling asleep, staying asleep, or waking up feeling as if she/he had not slept at all).**

**-Further, reports (low, fair, good) energy throughout the day.**

**-Child/parent acknowledges (poor, fair, good) appetite (if fair/poor, indicate how long this has persisted for). Any significant weight loss/gain.**

**MENTAL STATUS EXAMINATION**: **(see *Kaplan & Sadock’s Synopsis of Psychiatry: Behavior Sciences/Clinical Psychiatry* for Child MSE)**

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**CLINICAL FORMULATION: (Discuss diagnostic reasoning here.) ­­­­­­­­­­­­­­­­­­­­­­**

**DIAGNOSIS USING DSM-5:**

**(Begin with psychiatric diagnosis that the patient is being treated for; then, in order of relevance/importance/significance to the overall clinical picture, list the diagnoses. DSM-5 combines the first three DSM-IV-TR axes into one list that contains all mental disorders, including personality disorders and intellectual disability, as well as other medical diagnoses. Other conditions that are a focus of the current visit or help to explain the need for a treatment or test may also be coded.)**

**DIAGNOSIS:**

**PLAN OF TREATMENT:**