Experiential Healing Center
1713 Lockett Place
Memphis, TN 38104
(901) 372-0710

Youth Assessment

Name: _____ Date of Birth:_____

Address: _____ City, State, Zip_____

Home Phone: _____ Cell_____ Work_____

Email Address: _____

Name and phone number of someone we could reach in case of an emergency while you are attending your program_____

1) Are you under the care of a therapist? Yes____ No_____
   Name_____
   Address_____
   City,State,Zip_____
   Phone_____
2) Are you under the care of a Psychiatrist/? Yes___ No____
   Name_____
   Address_____
   City,State,Zip_____
   Phone_____
3) Are you under the care of Primary Care Provider? Yes ___ No____
   Name_____
   Address_____
   City,State,Zip_____
   Phone_____

3) Current School and Grade_____
   Name of School Counselor_____
   Phone and email of Counselor_____

Consent for Release of Information:

I hereby authorize the person(s) named in #1, #2, #3 and #4 above to exchange information regarding my mental and physical health history, diagnoses, treatment, problems and recommendations with the staff of The Experiential Healing Center. The purpose of this information is to assist EHC in evaluating my application for admission and coordinating care during and after this program. I understand I may revoke this

authorization at any time. This authorization will expire automatically without my expressed revocation three months after my discharge from the program. The information provided will be held strictly confidential by EHC and will not be released without my expressed written consent as required by law.

Signature_____ Date _____

Witness_____ Date _____
If the client is under 18 or has a guardian appointed by the court, the custodial parent or guardian must sign this release.

YOUTH PSYCHOSOCIAL ASSESSMENT DATE _____ **TIME** _____

SECTION I: IDENTIFYING INFORMATION

Name: _____ DOB: _____ Age**:** _____

Address: _____

City: _____ State: _____ Zip**:** _____

Phone: (h) _____ (w) _____ (c) _____

SSN: _____

Family Contact**:** _____

Relationship**:** _____ Phone(s): _____

Employer (if applicable): _____ Position: _____

Insurance Company: _____ Policy Number: _____

Current MD: _____

Current Therapist: _____

Current School: _____

Current Grade:

PRESENTING PROBLEMS AND SYMPTOMS: (What would you like to work on? Or, for parents, what would you say are your child's needs?)

_____

CURRENT BIOPSYCHOSOCIAL STRESSORS: (include any that are a priority for intervention. Educational, vocational, activities of daily living, recreation, social supports, current living situation, income, family, etc) _____

_____

EDUCATION / JOB TRAINING:

Highest grade completed: _____ Any diagnosed learning disabilities: _____

How is your school performance/what kind of student are you? _____

_____

Special Job Training or Skills: _____

FAMILY HISTORY:

Who Serves As Client's Parents: _____

_____

Number Of Siblings Living In The Home: _____

Current Relationship With Family Of Origin Members: _____

_____

_____

_____

_____

_____

_____

_____

Memories Of Significant Events During Childhood and/or Adolescence (include any physical, emotional or sexual abuse, addictive diseases, separation/divorce, death, abandonment, and outstanding memories): _____

_____

_____

_____

_____

Is there anyone you would like to potentially be involved in your treatment?

_____

Is there a history of mental illness or addiction in your family of origin? _____

_____

_____

Yes No History of Sexual Abuse: _____

When: _____ By Whom: _____

Reported: __ yes __ no. Explain: _____

Yes No History of Physical Abuse: _____

When: _____ By Whom: _____

Reported: __ yes __ no. Explain: _____

CURRENT FUNCTIONING (Rate your level of functioning in each area)

Family	___Good	___Moderate	___Severe
Relationship w/Partner / Friends	___Good	___Moderate	___Severe
Housing/Finances	___Good	___Moderate	___Severe
Work/School/Community	___Good	___Moderate	___Severe

Explain_____

_____

CULTURAL/SPIRITUAL INFLUENCES

Ethnicity_____

Are there spiritual or religious beliefs important to you to consider in treatment?

_____

_____

_____

Are there any cultural, ethnic, or minority identity issues to consider in treatment?

_____

_____

_____

Do you speak a language other than English as your primary language? ___Yes ___No

If Yes, what language? _____

What do you do for fun/hobby/recreation? _____

_____

_____

_____

Do you have a social support network? _____

_____

_____

What do you feel are your greatest strengths? (Or, for parents, your child's greatest strengths.)_____

_____

_____

_____

_____

CHILD BEHAVIOR CHECKLIST

Please indicate with **a check** any behaviors you have experienced in the past **six months.** Any behaviors for which there is a **history,** but are not being experienced currently, please indicate with **Hx.** (For parents, please do the same for any behaviors you have observed in the child.)

_____ sadness lasting more than 24 hours

_____ withdrawal

_____ isolation

_____ refusal to eat

_____ major weight fluctuation

_____ change in eating patterns

_____ bedwetting

_____nightmares

_____ difficulty sleeping

_____ hoarding

_____ thumb sucking

_____ running away

_____ headaches

_____ stomach problems

_____ skin problems

_____ nausea

_____ vomiting

_____ fatigue

_____ being overly talkative or charming

_____ affectionate with strangers

_____ difficulty making/ keeping friends

_____ does not feel guilty after doing something wrong

_____ overly interested in horror movies/ gore

_____ sets fires or interested in fire

_____ fighting (physical)

_____ verbally aggressive

_____ destruction of property

_____ cruelty to animals

_____ stealing

_____ poor attitude

_____ difficulty understanding the difference between what is real and what is fantasy

_____ hears voices or sees things that others do not see

_____ inappropriate touching of others

_____ promiscuity

_____ sexual abuse of others

_____ excessive masturbation

_____strange bathing or bathroom practices

_____ not affectionate to family members/ adults close to them

_____ breaking the law

_____acting more responsible than typical for his/ her age

_____ suicide attempts

_____ harming self

_____ low self-esteem

_____ talk of harming self

_____ denying all feelings

_____ not being able to concentrate

_____ educational issues

_____ blocking out memories

LEGAL HISTORY:

Pending Legal Issues/Status: _____

_____

Prior Legal History/Association With A&D Use: _____

_____

_____

_____

SECTION III: PREVIOUS TREATMENT- PSYCHIATRIC/CHEMICAL

	Facility	**Dates**	**Purpose**
Inpatient			
Residential			
Outpatient			

ALCOHOL AND NON-PRESCRIBED DRUG USE: (if Yes, please specify below.)

Have you ever used alcohol? Yes No

If so, how much and frequency: _____

Last use (Date): _____

Have you ever used non-prescription drugs? Yes No

If yes, how much and frequency: _____

Last use (Date): _____

Have you ever used nicotine? Yes No

If so, how much and frequency: _____

Last use (Date): _____

Have you ever abused alcohol or non-prescription drugs? Yes No

Have you ever used or abused prescribed drugs? Yes No

Has drinking or drug use affected your work, school, or family life? Yes No

Have you ever thought you should cut down on your drinking or drug use?

Yes No

Have you ever been annoyed by others' criticism of your drinking or drug use?

Yes No

Have you ever felt guilty about drinking or drug use? Yes No

Do you have a morning "eye opener?" Yes No

(explain)_____

_____

_____

_____

_____

_____

MEDICAL HISTORY/HOSPITALIZATIONS:

Yes No Medical emergencies (Seizures, stop breathing, blackouts, etc.)

Yes No Active infections (AIDS, Strep, Staph, Pneumonia, Hepatitis, etc.)

Yes No Pregnant or suspect pregnancy: _____

Yes No Previous hospitalizations or major surgeries (Surgery type, date/year, hospital, length of stay): _____

_____

Yes No Have you ever suffered from any kind of brain trauma at any point in your life? _____

_____

MEDICATIONS:

Medication (prescribed or over-the-counter)	Intended Use (why are you taking this med)	Prescribed Dosage and Frequency	Actual Dosage and Frequency	Last Dose	Prescribing Physician

If you are planning to attend one of our intensives, do you have any special dietary needs or requests?

_____

_____

If you could wake up tomorrow and have three things in your life be different from what they are today, what would those three things be?

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____