



PORTLAND DBT INSTITUTE, INC: TEEN/FAMILY ADDITIONAL ASSESSMENT

Client Name: _____

Date: _____

Name of person filling out form: _____

Relation to client: _____

School Information:

School Name:			
Grade:			
School Counselor:	Name:	Phone Number:	
	Email address:		

What problems does your child currently have in school?

<input type="checkbox"/>	Attendance problems	<input type="checkbox"/>	Individualized education plan
<input type="checkbox"/>	Poor grades	<input type="checkbox"/>	Held back
<input type="checkbox"/>	Behavioral problems Details:	<input type="checkbox"/>	Social problems Details:
<input type="checkbox"/>	Expelled When: Why:	<input type="checkbox"/>	Suspended When: Why:

Family Information:

What problems does your child currently have at home?

<input type="checkbox"/>	Doesn't do chores	<input type="checkbox"/>	Fights with siblings
<input type="checkbox"/>	Sneaks out	<input type="checkbox"/>	Runs away
<input type="checkbox"/>	Poor communication	<input type="checkbox"/>	Doesn't comply with limits and consequences
<input type="checkbox"/>	Other:		

What is the family structure?

Relationship	Age	Occupation	Anything we should know about the relationship?
Biological mother			
Biological father			
Stepmother <input type="checkbox"/> NA			
Stepfather <input type="checkbox"/> NA			
Adopted mother <input type="checkbox"/> NA			
Adopted father <input type="checkbox"/> NA			
Other:			

Who currently lives in your home?

Name	Age	Relationship	Anything we should know about the relationship?

Is your child from a divorced home?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Age at time of divorce?	
How did child respond to the divorce?	

Is your child adopted?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Age at time of adoption	
Country of origin	
Notable circumstances?	

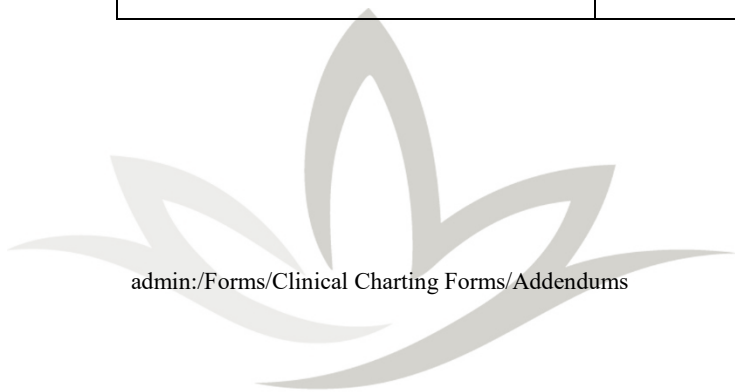
Is there a family history of any of the following?

Aggression, oppositional behavior	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
Attention, hyperactivity, impulsivity	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
Psychosis, schizophrenia	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
Mood problems, depression	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
Anxiety problems, excessive worry	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
Substance abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
Legal problems	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
Suicidality, self-harm	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:

Are there any current family stressors that seem relevant to your child's difficulties?

Developmental History:

Complications during pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
Substance use during pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:



Problems with child's development (Check those that apply)	<input type="checkbox"/> Motor development (walking, coordination, balance) <input type="checkbox"/> Speech development (stuttering, speaking) <input type="checkbox"/> Sensory development (vision, hearing, reactions to noise) <input type="checkbox"/> Cognitive development (unusual thoughts, odd ideas/fantasies) <input type="checkbox"/> Academic development (learning problems, ADHD) Details:
Has your child experienced any significant disruptions to attachment in their life, such as:	<input type="checkbox"/> Bullying/Peer aggression <input type="checkbox"/> Chronic Illness/Death of significant person in their life <input type="checkbox"/> Other (Describe): If yes to any of the above, please provide details:
Between ages 0-3, what were the childcare arrangements?	
Has your child ever had cognitive or psychological assessment done (e.g in the hospital or for an IEP)?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Details:
List a few of your child's strengths and interests:	

Behavior Change:

How have you tried to treat issues with your teen in the past?	<input type="checkbox"/> Therapy <input type="checkbox"/> Therapeutic (or other) programs <input type="checkbox"/> Discipline <input type="checkbox"/> Incentives/Rewards program <input type="checkbox"/> School consultation/Communication with teachers <input type="checkbox"/> Religious consultation <input type="checkbox"/> Other (Describe:)
How does your teen respond to discipline?	
Are there any forms of discipline which you have found to be especially effective or ineffective?	

Is there anything else you would like us to know about your teen or your family?

