**THERAPY CENTRE SERVICES**

**Child Initial Assessment Report**

**CLIENT DETAILS Date of Birth: / /**

|  |  |
| --- | --- |
| **Client Name :** |  |
| **Date of Initial Session :** |  |
| **Referral reference :** | **TCS Office use only** |

**CONTRACTING**

Confirmation that Statement of Understanding was talked through with client [ ]

Confirmation that measuring scales / questions will be talked through together [ ]

Confirmed with client that we will need to inform their referrer/parent/guardian if [ ]

we are worried for their safety / or risk is present

**GENERAL MENTAL HEALTH ASSESSMENT**

**Please specify main presenting issue:**

|  |  |  |
| --- | --- | --- |
| **Level A** | **Level B** | **Level C** |
| Academic concerns / Exam Stress | Anger / aggression or tantrums | ADHD |
| Anxiety (generalised) | Attachment issues | Adoption & Foster care issues |
| Bereavement | Cancer | Autism & Asperger’s |
| Blended family issues | Child neglect | Body dysmorphia |
| Bullying | Giftedness | Child abuse |
| Depression (low level / no risk) | Health anxiety | Developmental issues |
| Divorce issues | Health issues (physical) | Disruptive Mood Dysregulation (DMDD) |
| Education related stress | Hyperactivity | Eating disorders |
| Family issues | Insomnia / nightmares / night terrors | Gender identity |
| Fears / worries | Mood swings / mood disorder | Intellectual Disability |
| Feeling sad / SAD | Phobias | OCD |
| Insecurity | Poverty | Oppositional & Defiant Behaviours (ODD) |
| Irritability | Racial / ethnicity | Personality disorders |
| Self-confidence / self-esteem | Withdrawal / isolation | Self-harm / suicidal thoughts |
| School performance (decline) |  | Trauma |
| Sibling issues |  |  |
| Social anxiety |  |  |
| Social media |  |  |

**Can you confirm if you are experiencing, or have been formally assessed or diagnosed with any of the following;**

|  |  |  |
| --- | --- | --- |
| Anxiety | Hypomania / Mania | Psychosis |
| Bi-polar | PTSD | Schizophrenia |
| Body Dysmorphia | Paranoia | Other : (please specify) |
| Gender identity | Personality Disorders |  |

**RISK ASSESSMENT**

Please confirm if you have assessed any risk/concerns for the client’s safety or wellbeing:

**REFERRER RELATED ASSESSMENT**

Please confirm if there is information you would clinically recommend the referrer is aware of to best support this client:

**PARENT/GUARDIAN RELATED ASSESSMENT**

Please confirm if there is information you would clinically recommend the child’s Parent/Guardian is aware of to best support this client:

**RECOMMENDATION GIVEN**

|  |
| --- |
| **First session review** (summarise initial session, how you worked with your client and how the remaining sessions will be used)**Therapy Focus** (what are the intended main focuses of the sessions together)**Any other information :** |

**CORS or RCADS (this is optional and not a ‘requirement’ however if the client completes an assessment and agrees for the scores to be included in their report please provide the scores below);**

|  |  |
| --- | --- |
| **CORS (6-12 years)** |  |
| **RCADS (8-18 years)** |  |

**Date referred to school/referrer :**

**Outcome (Number of sessions authorised) :**