



INFANCY, CHILDHOOD & RELATIONSHIP ENRICHMENT INITIAL ASSESSMENT

(Used for Birth -5 years)

Karen Larsen, Director

Initial Contact Date: _____ Date Form Completed: _____

ASSESSING PRACTITIONER (Name and Discipline): _____

I. IDENTIFYING INFORMATION AND SPECIAL SERVICE NEEDS

Child Information

NAME: _____ **DOB:** _____ **Age:** _____

Other Names Used: _____ **GENDER:** Male Female

PREFERRED LANGUAGE(S): _____ **ETHNICITY(IES):** _____

Cultural Considerations, specify: _____

Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

Access issues (transportation, hours), specify: _____

Referred by (Name & Number): _____

BIOLOGICAL PARENTS & CONTACT INFORMATION

Mother's Name: _____

Father's Name: _____

Marital Status: _____ DOB: _____

Marital Status: _____ DOB: _____

Address: _____

Address: _____

Phone: _____ Work: _____

Phone: _____ Work: _____

Preferred Language: _____

Preferred Language: _____

Interviewed: Yes No Interpreter Used: Yes No

Interviewed: Yes No Interpreter Used: Yes No

Language Used for Interview: _____

Language Used for Interview: _____

PRIMARY CAREGIVER & CONTACT INFORMATION (Complete only if Biological Parent(s) are not the Primary Caregivers)

Guardian Adoptive Foster Kinship/Relative Group Home Other: _____

Date finalized: _____

Name: _____ Relationship to Child: _____ DOB: _____

Address: _____

Marital Status: _____ Phone: _____ Work: _____

Preferred Language: _____ Language Used for Interview: _____ Interpreter Used: Yes No

II. REASON FOR REFERRAL / CHIEF CONCERN

PRESENTING PROBLEM(S):

Type of help family is hoping to receive

CURRENT PRIMARY SYMPTOMS/BEHAVIORS

DESCRIBE ONSET, DURATION & FREQUENCY

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III. MENTAL HEALTH HISTORY / RISKS

PSYCHIATRIC HOSPITALIZATIONS: Yes No Unable to Assess

If yes, describe **DATES, LOCATION, AND REASONS**

OUTPATIENT TREATMENT: Yes No Unable to Assess

If yes, **DESCRIBE DATES, LOCATIONS, AND REASONS**

RECOMMENDATIONS, RESPONSE TO TREATMENT, PARENT/CHILD SATISFACTION

Prior Mental Health Records Requested: Yes No

Prior Mental Health Records Requested from: _____

TRAUMA or Exposure to Trauma: Yes No Unable to Assess

Examples include: Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of a crime, (8) experienced neglect, (9) experienced a referral to child protective services?

IV. MEDICATIONS

List "all" past and present psychotropic medications used, prescribed/non-prescribed, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

MEDICATION	DOSAGE/FREQUENCY	PERIOD TAKEN	EFFECTIVENESS / RESPONSE / SIDE-EFFECTS / REACTIONS

General Medication Comments

SUBSTANCE EXPOSURE / Parental Substance Use

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V. Physical Status / MEDICAL HISTORY

Does this client have an identified pediatrician or health care providers? Yes No
 Source of Information: Physician Consultation/Public Health Nurse Medical Records Parent/Caregiver
 Date of Last Physical: _____
PEDIATRICIAN'S NAME: _____ **PEDIATRICIAN'S PHONE:** _____

Acute Illness / Medical Problems (List):

Check any that apply:

- Colic Failure to Thrive Growth Delay Nutritional Concerns Asthma **ALLERGIES** Glasses/Vision Endocrine Problems
- Sensory/Motor Impairment Dental Cancer Ear Infections # Of Times Treated w/ Antibiotics per Year: _____
- Immune-Suppressed Deafness (Partial / Total) Blindness (Partial / Total) Lead Level Tested (Date/Details) _____

Vaccination up to date? Yes No Other Injuries/Trauma (Type): _____

Neurological: Seizure Disorder Autism Cerebral Palsy OTHER: _____

Brain Trauma (Date/Details): _____

Chronic Health Problems/Chronic Pain:

Visible Abnormalities/Malformations (*Head, Hands, Spine, Extremities, Face, Genitalia, Skin*):

History of Medical Procedures and/or Hospitalizations (NICU, surgeries) and the impact on child/dyad/family:

Details Regarding Above/Other Medical Comments:

VI. DEVELOPMENTAL HISTORY (DC: 0-5: Axis V)

Prenatal/Perinatal Information

Prenatal Care: None Intermittent Regular Other: _____

Prenatal Complication/Concerns (*Illnesses, accidents, stressors during pregnancy such as homelessness/domestic or interpersonal violence, parental use of alcohol, drugs, cigarettes, parental mental health*):

Postpartum Psychiatric Problems (*examples include anxiety, depression, psychosis, suicidal/homicidal ideation*): Yes No
 General Comments:

Birth History

Term (weeks): _____ Birth Weight (lb./oz.): _____ Birth Length (inches): _____ Mom's Age: _____

Labor Duration: _____ Child Days in Hospital: _____ Place of Delivery: _____ Dad's Age: _____

Type of Birth: Vaginal Induced C-Section Forceps Vacuum Type of Anesthesia Used: _____

Birth History Comments (*complications, perceptions of birth, length of NICU stay, if applicable*):

Parent/Caregiver Perceptions of Pregnancy & Birth (*Planned or surprise? Your/partner's reaction? Support?*)

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Breast-fed/Bottle-fed/Combination? Duration and age weaned? Age of taking cereal, solids. Types? Feeding difficulties (<i>include frequency & onset</i>) such as spitting up, sucking problems, refusal to eat, over-eating, fussy eater, GERD, Pica, Rumination, hoarding Food Aversions? Eating schedule/Frequency of eating Any weight or appetite changes? Signals of hunger/satiation? Self-regulation?	<h3 style="margin: 0;">Feeding</h3>
Where does the child sleep? Does that work for you and your family? Good sleeper? How did s/he sleep in past week? Last night? Is this typical? Is there a sleep routine/schedule? Length and frequency of naps, nighttime sleep? Sleep concerns (<i>e.g. difficulty falling asleep, waking, nightmares, night terrors, bed wetting, excessive snoring</i>) Frequency & onset Any sleep-related interventions attempted (<i>e.g. sleep training, sleep study</i>)?	<h3 style="margin: 0;">Sleeping Patterns</h3>
Describe your child's temperament: Examples: <ul style="list-style-type: none"> • <u>Easy going</u> = flexible, positive, calm, sustained attention • <u>Slow to Warm Up</u> = needs time to adjust; fussy, worried or timid at first but easy going once comfortable • <u>Difficult</u> = transitions are difficult, resists change, quick to cry, easily frustrated Is it easy for your child to transition from one activity to another? Is your baby colicky, fussy, cries a lot? How often & how long does your baby cry? Is it easy to read your baby's signals and moods? How responsive is your baby to you? Easy or difficult to soothe? What soothing strategies work best? Child's ability to self-regulate?	<h3 style="margin: 0;">Temperament / Regulation</h3>

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DEVELOPMENTAL MILESTONES <i>(Describe if not w/in normal limits and address the following domains: sensory, motor, socio-emotional, language, cognitive and adaptive/self-help)</i>	ENVIRONMENTAL STRESSORS <i>(Examples include moves, schools changes, separation, losses of family/friends, changes in family composition, SES, lifestyle, exposure to family conflict/violence, major illnesses, abuse/neglect, placements, etc.)</i>
Infancy: 0-6 months <i>Smiles back Rolls over Turns to sound Babbles Plays with objects</i>	0-6 months.
6-12 months <i>Stranger anxiety Sits upright/walks Responds to name Object constancy Says 1-2 words</i>	6-12 months
12-18 months <i>Reciprocal play Eats with spoon Tolerates noises Jumps with 2 feet Says 4-6 words</i>	12-18 months
18-24 months <i>Words for feeling Balances on 1 foot Brushes teeth/hair 2-3 word sentences Pretend play</i>	18-24 months
24-36 months <i>Toilet trained? Throws ball Uses "I" 2-step request Uses "big/little"</i>	24-36 months
36-60 months <i>Uses scissors Climbs a ladder Uses sentences Draws a line Symbolic play</i>	36-60 months

Development Assessment Tools & Results

Were the Ages and Stages Questionnaires completed? **Yes** **No**

If yes, enter the following Domain Scores:

Communication: _____

Gross Motor: _____

Fine Motor: _____

Problems Solving: _____

Personal-Social: _____

Comments:

Has any other developmental screening been conducted? **Yes** **No**

Comments regarding type and results:

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VII. PSYCHOSOCIAL HISTORY

Current Daycare, Child Care, Or School

Does Not Attend Child Care Attends Licensed Day Care Attends Unlicensed Child Care Cared for by Relatives

Currently Not Enrolled in Preschool Special Education Program

Child Care/Preschool Name: _____

Additional Child Care: _____

Contact Person: _____

Contact Person: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Days/Times Per Day Child Attends: _____

Days/Times Per Day Child Attends: _____

Parent Participation: _____

Parent Participation: _____

Notable Info: _____

Quality Of Relationships With Peers And

Date Of Last IFSP/IEP: _____

Staff: _____

IFSP/IEP Eligibility: _____

Early Intervention

Currently Not In Early Intervention Program

History Of Early Intervention Program

Date Enrolled: _____

Date Enrolled: _____

Name Of Program: _____

Name Of Program: _____

Contact Person: _____

Contact Person: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Days/Times Per Day Child Attends: _____

Days/Times Per Day Child Attends: _____

Services Receiving: _____

Services Receiving: _____

Parent Participation: _____

Parent Participation: _____

Quality Of Relationships With Peers And Staff: _____

Quality Of Relationships With Peers And Staff: _____

Regional Center Services

N/A Found Not Eligible Current Regional Center Client Never Evaluated

Regional Center Name: _____ Contact Person: _____

Address: _____ Phone: _____

Days/Times Child Attends: _____ Type Of Classroom: _____

Date Of Last IPP: _____ Regional Center Eligibility: _____

Regional Center Services And Hrs/Week: _____

Quality Of Relationships With Peers And Staff: _____

History of Child Care / Early Intervention / Preschool or Special Services

(Consider: licensed/unlicensed facility, #children in class, age range of children, nature of relationship with teachers/caregivers, peer relationships, parents' perception of support from teachers/caregivers, history of threatened or actual suspensions or expulsions from day care/pre-K, etc.)

CHILD ABUSE AND PROTECTIVE SERVICES INFORMATION (nature of allegations, age of occurrence, offender, dependency court action, child/parent response, placement and type, services)

CWS or Police Intervention: Yes No Is there a current visitation/involvement plan? Yes No

Family Visitation & Involvement Plan/Visitation schedule/Engagement in child's assessment:

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VIII. CURRENT FAMILY SYSTEMS REVIEW

Is the client homeless? Yes No Unable to Assess

If yes, when did the client become homeless (estimated date)? _____

Family Members Living in Child's Current Home (Identify relation & age)

Who else lives in your home?
Apt/house? Enough space?
Always lived here?

FAMILY RELATIONS

Get along with
each other?
Extended family?
Friends?

SOCIAL/ OTHER SUPPORTS?

CWS support?

FAMILY HISTORY:

Medical
Psychiatric
Legal/Criminal
Alcohol/Drug

Family cultural identity?
Immigration history?
Religion? Spiritual practice?

FAMILY STRENGTHS?

IX. RELEVANT PAST FAMILY SYSTEMS REVIEW (complete only if client has had more than one Relevant Family System)

Family Members Not Currently Living in Child's Home (Identify relation & age)

Who else lives in your home?
Apt/house?
Enough space?
Always lived here?

FAMILY RELATIONS

Get along with each
other?
Extended family?
Friends?

SOCIAL/OTHER SUPPORTS?

CWS support?

FAMILY HISTORY:

Medical
Psychiatric
Legal/Criminal
Alcohol/Drug

Family cultural identity?
Immigration history?
Religion? Spiritual practice?

FAMILY STRENGTHS?

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X. Observed Caregiver – Child Interaction *(Refer to the DC:0-5 Manual, Axis II Relational Context)*

Be sure to address relevant features from each **bolded** category below.

Behavioral Observations

Ensuring physical safety
Eye contact; physical contact
Affective tone
Enjoyment in joint play
Teaching/providing structure/socializing
Supporting child's developmental capacity
Appropriate limit-setting
Tolerating ambivalent feelings

Attunement, Balance & Congruence

Response to child's emotional needs/cues
Comfort when distressed
Showing interest in child's experience and incorporating (e.g., following child's lead)

Provide a description based on your observations of child & caregiver interaction.

XI. Behavioral Observations & Interview w/ Caregiver

Be sure to address relevant features from each **bolded** category below.

Behavioral Observations

Appearance, manner of relating, expressive style, mood/affect

Caregiver's Perceptions and Expectations

Of the child/baby, of his/herself and parenting, and of treatment

Insight/Strengths/Challenges

Adaptive capacity, strengths & assets, cooperation, insight, judgment, motivation for treatment

Relationship Between Caregivers

Problem-solving
Views of problem/strengths in child
Communication between caregivers
Conflict resolution
Emotional investment in each other
Behavioral regulation and coordination

Provide a description based on your observations of child & caregiver interaction.

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XII. MENTAL STATUS / Behavioral Observations: Child (See ICARE Reference Manual)

Include relevant features from below. Be sure to address relevant features from each **bolded** category below.

Appearance

Dress, grooming, unusual physical characteristics

Behavior

Activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

Socio-Emotional/Mood/Affect

Shy, fearful, labile, sad, blunt, irritable, aggressive, passive, depressed, anxious, risk to self or others, slow to warm up, easy going, difficult, ability to co-regulate and ability to self-regulate, frustration tolerance (e.g., reaction to transitions/adaptation)

Risk to Self/Others

Thought Content

Expressing worrisome thoughts, expressing developmentally inappropriate fantasies

Cognitive

Attention span and play are age appropriate, problem-solving ability

Communication/Language

Verbal/nonverbal, receptive/expressive, age appropriate, emotional expression

Sensorimotor

Visual, auditory, tactile, vestibular, proprioceptive, taste, textures, smells (over-reactive, under-reactive, typical), reaction to stimuli

Gross Motor/ Fine Motor

Coordination, motor planning, postural stability, coordination, tremors

Muscle Tone

Low, floppy, tense

Adaptive Functioning

Age appropriate self-care, feeding, toileting

Play

(e.g., parallel play, cooperative play)

Unusual Behaviors

(e.g., Repetitive behaviors, head-banging, breath-holding)

Strengths

Adaptive capacity, strengths & assets, cooperation

Provide a description of this child based on your observations.

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XIII. SUMMARY / CLINICAL FORMULATION / DIAGNOSIS

STRENGTHS OF THE CHILD AND FAMILY *(to assist in achieving treatment goals)*

CLINICAL FORMULATION: *Summarize/conceptualize all clinical information to determine the client's diagnosis and include initial proposal(s) for treatment. Identify any impairments in life functioning due to the client's diagnosis, if applicable, or how Specialty Mental Health Services can assist the client. Formulation should include risk factors as well as any significant strengths that can assist the client with treatment. Cultural factors related to the client's presenting problems, psychosocial and caregiving environment, and relationship between parents/caregivers should be considered, in addition to probability of not meeting socio-emotional developmental milestones, likelihood of later deterioration in functioning if not in services and impact on family.*

DC:0-5 Diagnosis (Please refer to the DC: 0-5 Manual):	ICD 10 DIAGNOSIS CODE: (To be entered in IBHIS)
Axis I (Clinical Disorders):	Primary: _____ Secondary: _____ Other: _____

Axis II : (Relational Context) *Consider v/z-codes in the Comments Section:*

Levels of Adaptive Functioning – Caregiving Dimension

Caregiver 1 (choose one)

- Level 1 – Well-adapted to Good-Enough Relationships
- Level 2 – Strained to Concerning Relationships
- Level 3 – Compromised to Disturbed Relationships
- Level 4 – Disordered to Dangerous Relationships

Caregiver 2 (choose one)

- Level 1 – Well-adapted to Good-Enough Relationships
- Level 2 – Strained to Concerning Relationships
- Level 3 – Compromised to Disturbed Relationships
- Level 4 – Disordered to Dangerous Relationships

Levels of Adaptive Functioning – Caregiving Environment

Caregiving Environment (choose one)

- Level 1 – Well-adapted to Good-Enough Caregiving Environment
- Level 2 – Strained to Concerning Caregiving Environment
- Level 3 – Compromised to Disturbed Caregiving Environment
- Level 4 – Disordered to Dangerous Caregiving Environment

Comments:

Axis III (Physical Health Conditions/Considerations):

Axis IV (Psychosocial Stressors) *Consider severity and buffers:*

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DC: 0-5 Diagnosis continued

Axis V (Developmental Competence):

Competency Domain Rating	Emotional	Social-Relational	Language-Social Communication	Cognitive	Movement and Physical
Exceeds developmental expectations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Functions at age-appropriate level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Competencies are inconsistently present or emerging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not meeting developmental expectations (delay or deviance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

XIV. Disposition/Recommendation/Plan *(Consider collaboration between systems and providers and its impact on the child and family)*

XIV. Referrals Given

Service: _____

Referred To: _____

Date: _____ Contact Name: _____ Phone Number: _____

Service: _____

Referred To: _____

Date: _____ Contact Name: _____ Phone Number: _____

Service: _____

Referred To: _____

Date: _____ Contact Name: _____ Phone Number: _____

XV. SIGNATURES

ASSESSOR'S SIGNATURE TITLE DISCIPLINE DATE

CO-SIGNATURE TITLE DISCIPLINE DATE

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