C.O.P.E. CENTER, INC.
CHILD/ADOLESCENT BIO-PSYCHOSOCIAL SELF ASSESSMENT

C.O.P.E. Center, Inc. wishes to provide you with the best services possible. In order to do so we need to obtain the following information. This information will be used to assign you to the most appropriate program or therapist. Your assigned therapist will review this information with you to help develop your Treatment Plan.

Please be aware that this information is confidential with the following exceptions: (1) if you sign a Release of Information form; (2) upon receipt of a court order by a judge; (3) in the event of a valid emergency; (4) if you commit a crime at the program or against any person at the program, or threaten to commit such a crime; or (5) upon suspicion of abuse or neglect; (6) upon receipt of a request that may be governed by Florida Statutes, such as Workers Compensation. If there is information you don't wish to write down, explain to your therapist during interview.

Unless otherwise noted, all questions should be answered regarding the person who will be receiving services (for example: your child). <u>If more space is needed, continue responses on back of page</u>. Thank you for your assistance.

Name of person to receive services: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Other names used: _____

Who referred you to treatment? __Self __Dept. Children & Families __Parents

__Family member __Physician __School __Work __Other, specify: _____

Who has Legal Custody of Child? _____
Name(s) and relationship(s) of persons providing assessment information: _____

_____
Are you willing and able to participate in client services when appropriate? Yes No
Comments: _____

PRESENTING PROBLEM

Describe specifically the mental, emotional, and/or behavioral problems the Child is currently experiencing. Include how often; how long: _____

_____

_____
History of the problems (Describe age and circumstances when problems began):

_____

_____
Issues important to you/child: _____

_____

PAST MENTAL HEALTH TREATMENT

Has the Child ever been in the hospital for mental health treatment?	**Yes**	**No**
Has the Child ever been in outpatient care for mental health treatment?	**Yes**	**No**
Has the Child ever been in an in-school treatment program?	**Yes**	**No**
Has the Child ever been in a residential treatment center?	**Yes**	**No**

Name of Facility Location Reason for Treatment Start/End Dates How did child do?

_____
_____
_____
_____

Was treatment completed? **Yes** **No**
Did Child have a positive experience in previous treatment? **Yes** **No**
Was Child compliant with treatment recommendations? **Yes** **No**
Comments regarding treatment history: _____
_____

Do you feel that the child is at risk for dangerous behaviors? **Yes** **No**
What situations increase the risk for dangerous behaviors? _____
_____
What does child do to cope with these risks? _____
_____
Describe any warning signs for the dangerous behaviors: _____
_____

EDUCATIONAL / DAYCARE HISTORY

Current school: _____ Current Grade: _____
Current daycare: _____

History of:
Academic Problems: **Yes** **No** Academic Strengths: **Yes** **No**
If yes, explain: _____
Has Child been retained? **Yes** **No**
If yes, explain: _____
Behavior Problems: **Yes** **No**
If yes, explain: _____
Educational Evaluations: **Yes** **No**
If yes, explain: _____
Special Education Placement: **Yes** **No**
If yes, explain: _____

EMPLOYMENT HISTORY

Has the Child had any Vocational training? **Yes** **No**
Describe: _____
Has the Child had any Vocational problems? **Yes** **No**
Describe: _____
Has the Child ever worked? **Yes** **No**
Describe: _____

SOCIAL RESOURCES

Is the Child able to form and maintain relationships with family/friends? **Yes** **No**

Peer relationships: _____

_____

What are the Child's favorite activities: _____

_____

Hobbies and interests: _____

_____

Does the child have a Girlfriend or Boyfriend: **Yes** **No**

Current problems with close relationships? **Yes** **No**

Describe: _____

Sexually active: **Yes** **No**

Describe: _____

Gang involvement: **Yes** **No**

Describe: _____

LEGAL HISTORY OF CHILD/ADOLESCENT

If history of legal issues, please explain:

_____

_____

Arrest charges pending: **Yes** **No**

Describe: _____

Previous arrests: **Yes** **No**

Describe: _____

Probation: **Yes** **No**

Describe: _____

Court supervision: **Yes** **No**

Describe: _____

Family court/status offenses: **Yes** **No**

Describe: _____

Restitution: **Yes** **No**

Describe: _____

DEVELOPMENTAL HISTORY

Were there complications with the pregnancy? **Yes** **No**

Describe: _____

Did mother sustain any major injury/illness while pregnant? **Yes** **No**

Describe: _____

Did mother use tobacco, alcohol, street drugs or prescription drugs during pregnancy?

Yes **No**

Describe: _____

Was the delivery premature or overdue? **Yes** **No**

Describe: _____

Were the complications with the labor/delivery? **Yes** **No**

Describe: _____

DEVELOPMENT

Gross motor development: Early Average Delayed Don't Know
Fine motor development: Early Average Delayed Don't Know
Cognitive development: Early Average Delayed Don't Know
Expressive communication: Early Average Delayed Don't Know
Receptive communication: Early Average Delayed Don't Know
Self-care (e.g., dressing, feeding, toileting):
Early Average Delayed Don't Know
Social skills: Early Average Delayed Don't Know
Comments: _____
_____

INFANT TEMPERAMENT

Easy to comfort: **Yes** **No**
Quiet / aloof: **Yes** **No**
Excessive Irritability: **Yes** **No**
Overactive: **Yes** **No**
Describe early sleeping and feeding habits: _____
_____
_____

MEDICAL HISTORY

What is Child's general health: **Excellent** **Good** **Fair** **Poor**
Describe: _____
Immunization Record Current? **Yes** **No**
Any significant illnesses or injuries? **Yes** **No**
Describe: _____
_____
_____
Any neuropsychological (brain) issues? **Yes** **No**
Explain any other medical issues; identify if issues are current or in the past:
_____
_____
_____

TRAUMATIC EVENTS

Current or past experience of being abused or neglected? **Yes** **No**
List: _____
Describe the above, or any other traumatic experience: _____
_____
Has the child received services for the past abuse? **Yes** **No**
If no, would you be interested in receiving services? **Yes** **No**

MEDICATIONS

Has Child taken any medications in the past two weeks? **Yes** **No**

Has Child taken any medications for any reason? **Yes** **No**
Was Child compliant with medications in the past? **Yes** **No**

Medications Taken (List All):

Name	Dosage	Reason Prescribed and Date	Reason Ended and Date

List any other medication not included above:

_____

_____

SUBSTANCE ABUSE HISTORY

Does the Child have a history of substance abuse? **Yes** **No**
Describe: _____

_____

Drugs or Alcohol Used (by preference, with #1 being most preferred):

	Drug?	How Taken?	Age Started?	Frequency of use?	Most Recent Use?
1.					
2.					
3.					
4.					
5.					
6.					

Does the Child currently live with a person using substances? **Yes** **No**
Has the Child been exposed to substance abuse? **Yes** **No**

Does the Child use tobacco products? **Yes** **No**
Describe: _____

OTHER ADDICTIONS (Pornography, video games, internet, gambling, etc.)? **Yes** **No**
Describe: _____

_____

PSYCHOSOCIAL HISTORY

Are there family issues that need to be addressed in treatment? **Yes** **No**
Does the child have a positive relationship with parents? **Yes** **No**
Does the child have a positive relationship with siblings? **Yes** **No**

Current living situation, history, and information about the child's family. May include cultural, religious, income, housing information, other agencies involved, and family relationships. _____

_____

_____

Are there any cultural issues that could interfere with treatment? **Yes** **No**
Describe: _____
_____

Is there current DCF (HRS) involvement? **Yes** **No**
Has there been past DCF (HRS) involvement? **Yes** **No**
Describe: _____
_____

CURRENT LIVING SITUATION
Is child in need of food, clothing, or shelter? **Yes** **No**
Describe: _____
_____
Current living arrangement: _____
_____
Number of persons, other than the Child, currently living in the home? _____

LIST HOUSEHOLD MEMBERS

Name?	**Relationship?**	**Date of Birth/Age?**	**Address?**	**Phone?**
1.				
2.				
3.				
4.				
5.				
6.				

Living environment (condition of the home): **Good** **In need of repair** **N/A**
How many times has the Child's residence changed within the last two years? _____
Explain: _____
_____

How would you rate the family's Socioeconomic Position:
__Well Above Average __Above Average __Average __Below Average __Well Below Average

Do you possibly qualify for public assistance? **Yes** **No** **Unknown**

What are the Child's current support systems:_____
_____
Describe: _____

CHILD'S STRENGTHS
List: _____
_____
CHILD'S ABILITIES
List: _____
_____
CHILD'S/FAMILY'S PREFERENCES
List: _____
_____

PAST SIGNIFICANT EVENTS (Check any of the following that apply):
__Significant medical condition of parent/caregiver
__Medical condition of child
__Post-partum adjustment problems of mother
__Mental illness of parent/caregiver
__Substance abuse of parent/caregiver
__Separation/divorce of parent/caregiver
__Adoption
__Abandonment of significant adult caregiver
__Death of parent/caregiver
__Mental retardation of parent/caregiver
__Incarceration of parent/caregiver
Comments: _____
_____

Has the Child ever lived in any of the following settings? **Yes** **No**
__Relative's home __Foster family __Orphanage
__Group home __Therapeutic foster care __Halfway house
__Emergency shelter __Correctional facility __Residential substance abuse facility
__Detention facility __Homeless __Hospital
__Other __Residential treatment center

Comments: _____
_____

Most <u>restrictive</u> living situation in last 3 months:
_____

SPIRITUAL CONSIDERATIONS
Primary religious affiliation: _____

Does Child have spiritual strengths? **Yes** **No**
Does Child have spiritual problems? **Yes** **No**
Describe: _____
_____

Have any **<u>family members</u>** had a history of Mental Illness: **Yes** **No**
If so, describe illness (give diagnosis if known): _____
_____
Family History of Substance Abuse? _____
_____
Family History of Criminal Activity? _____
_____
Family History of Violent Behavior? _____
_____
Family History of Medical Problems?_____
_____

STOP HERE PLEASE	

INDIVIDUALIZED RECOVERY PLAN
(TENTATIVE)

What are the client's goals and preferences for treatment? Will there be family involvement?

_____
_____
_____

Problems Identified	**How Problem is to be Addressed** (Indicate if deferred and why)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Identified educational needs: (Include where and how these needs will be addressed): _____

_____

_____

Barriers to Treatment Identified: (check only those that apply)

__Educational limitations __Developmental delays __Lacking Economic Resources __Low Motivation
__Unemployment __Transportation __ Physical Problems __Homelessness
__Limited Family/Social Support __Limited Insight
__Other _____

Treatment Services/Modalities Recommended: (Include service, modality, and frequency. Include external referral):

_____
_____
_____
_____

Criteria for Discharge:

_____
_____
_____
_____

_____ _____

Client (or Guardian) Signature/Date **Clinician Signature/Credentials//Date**

I understand the purpose of this Treatment Plan. I was, and will continue to be, involved in decisions regarding my treatment.

_____

Qualified Professional/Supervisor/ Signature/Credentials/Date

The diagnosis and treatment recommendations have been reviewed and appear to be appropriate given the individual's condition at this time.