

## Behavioral Assessment

Name:

Assessment Dates:

D.O.B.

Age:

Parents:

PCP:

Participants:

### Presenting Problem/Reason for referral

(Present symptoms, who recommended eval, etc. . .)

### Current behaviors

Home:

School:

Peers:

Family:

Emotional Problems:

### Social History:

(Living environment, daycare?, custody/visitation, family structure, abuse/neglect, Discipline strategies used.)

### Academic History

Preschool:

Kind:

First:

Previous school evaluations and services:

### Developmental History:

Pregnancy

Delivery:

Development:

(Age sitting, walking, talking, potty training, feeding self Cheerios appropriate? Sleeping problems? Bed wetting? Motor development. Tics? Coordination issues? )

Medical History:

Family History

(Family history of mental illness, ADHD, pertinent medical problems)

Assessment

(Rating scales and how they scored on each scale. Age of onset of symptoms. Other co-morbid conditions.)

Summary

(Summary of symptoms and dx)

DSM-IV

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Recommendations

- Recommend referral to provider for medication recommendation
- Recommend return visit to behavioral health for behavior management program and treatment of co-morbid conditions on a bi-weekly / monthly/ quarterly basis
- Recommend behavioral health re-assessment on a quarterly / yearly basis
- Recommend referral to community agency: \_\_\_\_\_

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Community Counseling Therapist

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Date