Life Management Center
Of Northwest Florida Inc.

Interactive Core Assessment

Ages 6 to 12 years

Client Name _____ **Child's Age** _____ **Today's Date:** _____

Name of the person completing the survey _____ **Relationship to Child** _____

After you complete this information, you will be visiting with your service coordinator to talk about how best we can help you. If you need any help completing this form, ask your service coordinator or someone at the front desk if you are at a service site.

Why are you seeking services from Life Management Center at this particular point in time? _____

_____

What is your goal? _____

_____

PRESENTING PROBLEM

Check the problem(s) your Child is having:

☐ Sleep problems	☐ Lying	☐ Unmanageable behavior	☐ Pregnancy
☐ Run away	☐ Sexual Behavior	☐ Problem w/ sexual behavior	☐ Fighting
☐ Hears voices	☐ Hyperactive	☐ Victim of abuse	☐ School problems
☐ Solving problems	☐ Drug/alcohol abuse	☐ Friend problems	☐ Verbally aggressive
☐ Self-harm	☐ Stealing	☐ Toileting Problems	☐ Anxiety
☐ Legal problems	☐ Eating Problems	☐ Withdrawn	☐ Inattentive
☐ Other (explain)			

Were you referred by someone to come to Life Management Center? ☐ Yes ☐ No **If yes, please identify below:**

☐ Another agency _____ ☐ Friend ☐ Teacher ☐ Pastor ☐ Emergency Services referral ☐ Other: _____

PROBLEM HISTORY

Has your Child ever received counseling or behavioral health services in the past? ☐ Yes ☐ No **If yes, please complete the following:**

Provider	Reason	Ages	Effectiveness		
			Poor	Fair	Good
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Please list any prescribed psychiatric medications your Child is taking now or has taken in the past (if any):

Medication Name	Dosage	Frequency	Prescribing Physician	Effectiveness		
				Poor	Fair	Good
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Has your Child experienced highly stressful events such as: ☐ Neglect ☐ Physical abuse ☐ Sexual abuse ☐ Loss of a loved One

☐ Other kind of loss ☐ Witness to a highly disturbing situation

Do you have any concerns about drug, tobacco or alcohol use by your Child? ☐ Yes ☐ No

Are there family problems with substance abuse or mental illness that may help explain your Child's problems? ☐ Yes ☐ No

Family Background

Who has LEGAL custody of the Child? Name: _____ Relationship: _____

If the Child does not live with the birth parent, who does the Child live with? _____

How many homes has the child lived in since birth? _____

Who lives in the Child's household now?

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there other sisters/brothers not listed? ☐ Yes ☐ No Do the parents of the Child live in the same household? ☐ Yes ☐ No
If No, are they ☐ Living ☐ Separated ☐ Divorced ☐ Never Married

If either parent has remarried, how many times? For Father _____ For Mother _____

What is the name of the parent the Child does <u>not</u> live with? _____

Does the Child have contact with the parent the Child does not live with? ☐ No ☐ Yes If yes, how often? _____

Has the Child ever been in foster placement? ☐ No ☐ Yes If yes, how many times? _____

☐ Now If now, who is the Child's Care Manager? _____

Is the Child legally adopted? ☐ Yes ☐ No At what age did this occur? _____ Is the Child aware of the adoption? ☐ Yes ☐ No

Check the problems that the family is having:

☐ Homelessness	☐ Rules	☐ Fighting between kids	☐ Talking
☐ Work pressure	☐ Adolescent control	☐ Divorcing/Separating parents	☐ Ex-husband or wife
☐ Showing affection	☐ Religious differences	☐ Outside interference	☐ Solving problems
☐ Household responsibilities	☐ Expressing feelings	☐ Personal privacy	☐ Violence between parents
☐ In-law problems	☐ Time spent together	☐ Toileting	☐ Unemployment
☐ Housing	☐ Transportation	☐ Parents disagreeing about kids	☐ Paying bills
☐ Medical Issues	☐ Alcohol, drug misuse	☐ Making decisions	
☐ Other, explain:			

Medical/Developmental History

Were there any complications during pregnancy or birth? ☐ Yes ☐ No Birth weight? _____lbs _____ ozs

Was this a full-term pregnancy? ☐ Yes ☐ No If no, how many weeks was the pregnancy? _____

Did mother use during pregnancy ☐ Prescription medications ☐ Illegal drugs ☐ Alcohol ☐ Tobacco

Were there any problems right after the Child's birth? ☐ Yes ☐ No

Child's doctor's name: _____ When was the Child's last physical? _____ Shots up-to-date? ☐ Yes ☐ No

Please list any allergies your Child has: _____

Any drug allergies? ☐ Yes ☐ No If yes, what drugs? _____

Current medications (if any): (Include prescribed, over-the-counter, herbal remedies, vitamins, etc.)

Medication Name	Dosage	Frequency	Prescribing Physician	Effectiveness		
				Poor	Fair	Good
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Did your Child seem to develop about the same as other children in such areas as talking, crawling, walking and potty training? ☐ Yes ☐ No

Can other adults understand your Child's speech ☐ Yes ☐ No Does your Child have any hearing or vision problems? ☐ Yes ☐ No

Has the Child ever had an unusual sickness or on-going health problem? ☐ Yes ☐ No

Educational / Legal Information

How many schools has the child attended since Kindergarten ? _____ What grade is the child in now? _____

Name of school: _____ Are the Child's grades: ☐ above average ☐ average ☐ below average

Has the Child ever: ☐ Skipped a grade ☐ Been held back ☐ Been home schooled ☐ Been in an advanced class

Has the Child had special help for: ☐ Learning ☐ Behavior ☐ Emotional control ☐ Speech ☐ Physical Limitations

Does anyone in the Child's family have a learning problem? ☐ Yes ☐ No

Has the Child ever: ☐ Been arrested ☐ Done community service hours ☐ Been in detention ☐ Been on community control

Strengths and Resources

Does your family receive?

☐ Child Support	☐ SSI	☐ Medicaid	☐ Subsidized Housing
☐ Food Stamps	☐ TANF	☐ WIC	☐ SSA
☐ Other, Explain			

What are the strengths of family?

☐ Good Health	☐ Extended Family Support	☐ Stable Income	☐ Little Debt
☐ Safe Neighborhood	☐ Shared Parenting Beliefs	☐ Good Housing	☐ Shared Interests
☐ Good Education	☐ Good Communication	☐ Harmonious Relationships	☐ Faith
☐ Cultural Heritage	☐ Time Spent Together	☐ Adequate Transportation	☐ Humor
☐ Good Housekeeping	☐ Good Credit	☐ Mutual Respect	☐ Regular Mealtimes
☐ Other, Explain:			

What are the strengths of the Child?

☐ Healthy	☐ Good student	☐ Athletic	☐ Sense of humor
☐ Artistic	☐ Relates well to adults	☐ Gets along well other kids	☐ Good energy level
☐ Able to concentrate	☐ Self-reliant	☐ Knows right from wrong	☐ Manages feelings
☐ Other Explain:			

Special Needs

Do you or your Child need any of the following to participate in services:

☐ Wheelchair ☐ Equipment to assist hearing ☐ Signing services ☐ Materials for visual challenges ☐ Other (specify)_____

Are there cultural needs (ethnicity, language, religion, customs, and beliefs) that are important to our work with the Child or family? ☐ Yes ☐ No

Does your Child have any of the following needs in addition to mental health services for which you would like a referral? ☐ Yes ☐ No

If yes, specify: ☐ Educational ☐ Medical ☐ Speech ☐ Other (Specify) _____

The above information is complete and accurate to the best of my knowledge.

_____ _____

Signature of parent/guardian *Date*