Child Initial Assessment

The following information will assist our clinical staff with getting to know your child and completing the initial assessment appointment. **It is very important to fill this out as completely as possible prior to your initial appointment**. Providers may ask you to fill this out prior to being seen. Please use black ink.

Child's legal name	Preferred name	Child's date of birth	Child's age
Form completed by			Date form completed
What sex was your child assigned at birth? ☐ Male ☐ Female	Gender identity		
What pronouns should we use to refer to your child? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other ______			

What prompted you to schedule an Eating Disorder Assessment for your child at Melrose Center? ______

______

______

Please list the name of who referred you to Melrose Center? What is their relationship to you?

______

I have heard about Melrose Center from (check all that apply):

☐ Friend/Family/Neighbor ☐ Medical or Mental Health Provider ☐ Online (Facebook, website, search)
☐ Advertisement (Radio, print, billboard) ☐ School Social Worker or Counselor ☐ Other ______

LIVING SITUATION

Parent

Name	
Street address ☐ Rent ☐ Own	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Parent

Name	
Street address ☐ Rent ☐ Own	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Family status:

☐ Married ☐ Separated (in______ / ______) ☐ Divorced (in______ / ______) ☐ Never married

If separated, child's primary residence is with whom? ______

If parents are divorced or separated, how often does the child visit with the other parent? ______

______

Name of child's legal guardian ______

Name of child's foster parents ______

Foster parents' address ______

Stepparent	
Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Stepparent	
Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Current living arrangements

- ☐ Lives with both parents (biological or adoptive) in same household
- ☐ Single parent
- ☐ Shared custody (parents in different households) primary residence ___________
- ☐ Relative/guardian's home
- ☐ Hospital
- ☐ Residential care
- ☐ Temporary housing
- ☐ Friend's home
- ☐ Hospital
- ☐ Homeless
- ☐ Other, describe ______________________________

Is your child adopted? ☐ No ☐ Yes. If yes, how old was your child at the time of adoption? ___________

Is your child aware of the adoption? ☐ No ☐ Yes

FAMILY ENVIRONMENT/RELATIONSHIPS

Are any other issues seriously affecting your family of which you would like us to be aware?

____

____

____

Has your child ever experienced or witnessed any of the following?

- ☐ Domestic violence/abuse
- ☐ Community violence
- ☐ Sexual assault/molestation
- ☐ Emotional abuse
- ☐ Physical neglect
- ☐ Natural disasters
- ☐ Physical abuse
- ☐ Fire
- ☐ Other ______________________________

☐ Yes ☐ No Have you or your child been involved with any of the following county resources?

- ☐ PCA (Personal Care Assistance)
- ☐ Foster care
- ☐ County social worker
- ☐ Respite care
- ☐ PACER (Parent Advocacy Coalition for Educational Rights)
- ☐ The ARC
- ☐ Developmental disorder social worker
- ☐ Other ______________________________

☐ Yes ☐ No Does your child have a history of legal charges? Please describe.

____

☐ Yes ☐ No Is your child currently on probation?

☐ Yes ☐ No Has your child ever been on probation?

☐ Yes ☐ No Has your child ever been court-ordered into chemical health or mental health treatment?

☐ Yes ☐ No Has your child ever had involvement with Child Protection Services (CPS)? Please describe.

____

Name of CPS caseworker(s) assigned to family (if applicable)

☐ None reported ______________________________

Name of guardian ad litem (GAL) or court appointed special advocate (CASA) assigned to family?

☐ None reported ______________________________

NUTRITION AND FEEDING

Current weight ____________ Height ____________ Date ____________

☐ Yes ☐ No Does the child have difficulty gaining weight?

☐ Yes ☐ No Have there been past or present nutritional concerns?

☐ Yes ☐ No Has it been difficult for your child to eat at family functions, restaurants, or birthday parties?

What foods does your child avoid? ____________

What help have you had in managing nutrition? (e.g., dietitian from Pediatric Home Services, nutritional consultations, primary doctor's suggestions, special formula, foods, etc.) ____________

List any family (immediate/extended) medical history of feeding/eating disorders, GI disorders, food peculiarities. Include ages especially for siblings. ____________

Are you having any problems managing the child's behavior related to feeding? (e.g., refusal to eat, vomiting, eating very slowly, tantrums) ____________

What eating–related symptoms or behaviors does your child experience?

	Current & Frequency	**Past & Frequency**
Overeating/Emotional Eating/Binge eating		
Purging (self-induced vomiting)		
Restricting food / under-eating		
Compulsive or excessive exercise		
Diet pills / supplements or weight loss programs		
Hiding food		
Excessively Picky eater		
Laxative use		
Fears of food		

When did you first notice your child had a problem with eating and what was going on in their life then?

Eating Pattern (over past 1 month)

Breakfast ____________

Snack (a.m.) ____________

Lunch ____________

Snack (p.m.) ____________

Dinner ____________

Snack (evening) ____________

Fluid intake ____________

What rules does your child follow around eating? ____________

BIRTH HISTORY

Term (# of weeks) ______________ Premature (# of weeks) ______________

Prenatal care? ______________

Birth weight ______________ Length ______________

List any significant birth history (e.g., difficult delivery, use of oxygen, extended length of stay in the hospital/NICU, use of ventilator, etc.) ______________

EDUCATION

☐ Yes ☐ No Does the child currently attend school or receive other school services?

If yes, Where? ______________ Grade ______________

Special education services ______________

☐ Yes ☐ No Is your child involved in any sports or after-school activities? If yes, please explain:

MEDICAL HISTORY

Please list all of your child's medications, or bring a list with you of all prescribed, over the counter drugs, vitamins and/or herbal supplements that he/she currently takes:

☐ Yes ☐ No Does your child have any history of medical problems? If yes, please explain:

☐ Yes ☐ No Does your child have any history of surgeries? If yes, please explain:

☐ Yes ☐ No Has your child ever been hospitalized? If yes, please explain:

☐ Yes ☐ No Does your child have any known drug, environmental, or food allergies? If yes, please explain:

MEDICAL HISTORY continued

Date of last bowel movement? ___________________________

Has your child experienced any of the following in the past 3 months? Check all that apply.

Medical

- ☐ Lightheadedness
- ☐ Dizziness/fainting
- ☐ Chest pain
- ☐ Sensitivity to cold
- ☐ Leg cramps
- ☐ Shortness of breath
- ☐ Irregular pulse
- ☐ Heart racing
- ☐ Neck/back pain
- ☐ Excessive sweating
- ☐ Blueness of lips/fingers
- ☐ Chronic pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowel problems
- ☐ Stomach problems
- ☐ Trouble swallowing
- ☐ Appetite change
- ☐ Heartburn
- ☐ Cough
- ☐ Vomiting blood
- ☐ Dry mouth
- ☐ Visual disturbances

Mood

- ☐ Depressed mood/unhappy
- ☐ Little interest or pleasure in most activities
- ☐ Appetite or weight changes
- ☐ Trouble falling asleep
- ☐ Waking up in the middle of the night
- ☐ Sleeping too much
- ☐ Fatigue
- ☐ Feelings of worthlessness/guilt
- ☐ Problems concentrating
- ☐ Problems making decisions
- ☐ Thoughts of death
- ☐ Too much energy
- ☐ Impulsive behaviors
- ☐ Have gone days without sleeping

Anxiety

- ☐ Worry about a number of things
- ☐ Feel anxious majority of the time
- ☐ Difficult to control the worry
- ☐ Anxiety or fear in social situations
- ☐ Fear others are judging them
- ☐ Worry they will embarrass themselves
- ☐ Panic attacks
- ☐ Racing thoughts
- ☐ Feeling restless
- ☐ Obsessive thinking
- ☐ Rituals to lower anxiety
- ☐ Nightmares
- ☐ Intrusive memories/ flashbacks
- ☐ Avoid people or places that bring up memories

☐ Yes ☐ No Has your child ever contemplated suicide in the past or ever engaged in any kind of self-harm behavior (suicide attempt or self-harm)? If yes, please explain:

____

____

☐ Yes ☐ No Has your child ever talked with a psychologist, therapist, counselor, chaplain or other professional about emotional or personal concerns? If yes, please complete the following:

Reason for treatment	Setting (inpatient/outpatient)	Dates	Who did they talk to?

☐ Yes ☐ No Do you have any other concerns about the child's behavior at home or school? If yes, please explain:

____

____

Place an “X” in appropriate boxes to identify all illnesses/conditions in your child’s blood relatives:

Illness/Condition	Family Member							
	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Depression								
Chronic/General anxiety								
Bipolar/manic depression								
Schizophrenia/psychosis								
Eating disorder								
Psychiatric hospitalization								
Alcohol/drug abuse								
Suicide/suicide attempt								
Phobias/Fears								

What are your child’s weak areas? ____________________

What are your child’s strengths? ____________________

Does your child have friends? ____________________

What does your child do for fun? ____________________

Please describe any religious affiliation or spiritual beliefs and their impact, if any, on your child’s service preferences:

Please indicate your child’s ethnicity or cultural identification: ____________________

Is there anything else you feel it is important for us to know right now? ____________________

What do you want to achieve with eating disorder treatment for your child and family? ____________________

Signature of person filling out the form	Printed name	Date