

Child and Caregiver Assessment Tool

A. Patient / Family Information:

Patient's name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____

Mother's Name: _____

Father's Name: _____

Mother's Age: _____

Father's Age: _____

Mother's Occupation: _____

Father's Occupation: _____

Home Address: _____

Home Address: _____

Telephone (day): _____

Telephone (day): _____

Telephone (evening): _____

Telephone (evening): _____

Parent's Marital Status: _____

Languages Spoken: _____

Legal custody of children: _____

Physical custody of children: _____

Are there other relatives or adults that are important caretakers for your child (i.e. stepparent, significant other, grandparent)? Please list:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list information about your child's brother or sisters below (please include stepsiblings):

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. School and Other Interests:

Current School: _____

Address: _____

Telephone: _____

Grade: _____

Teacher's Name: _____

School Nurse's Name: _____

Does your child receive special education services? _____ If yes, please describe: _____

Has your child ever repeated a grade? _____ If yes, which grade(s): _____

Does your child have:

1. Any subjects that he/she especially enjoys? Yes No
If yes, what are they? _____
2. Any subjects that are especially difficult? Yes No
If yes, what are they? _____
3. Favorite hobbies, interests and/or toys? Yes No
If yes, what are they? _____
4. A part-time job (i.e. babysitting, paper route)? Yes No
If yes, what is it? _____

C. Development

1. At what age did your child:
Walk _____
Talk _____
Toilet Train _____
Start School _____
2. Prior to the diagnosis of the current illness, has your child had any problems with the following:
 - a. Eating? Yes No
If yes, please explain: _____

 - b. Sleeping? Yes No
If yes, please explain: _____

 - c. Separation? Yes No
If yes, please explain: _____

 - d. A major illness? Yes No
If yes, please explain: _____

 - e. Prior hospitalizations? Yes No
If yes, please explain: _____

D. Behavioral Patterns:

In general how would you describe your child's behavior prior to diagnosis?:

	Not at all	A little	A lot	N/A
Shy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plays well with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plays well alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outgoing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Uncooperative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not at all	A little	A lot	N/A
Angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distractible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imaginative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Controlling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flexible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Have you ever been concerned about your child's behavior? If so, how? _____
When? _____
- What have you found to be the most effective way to get your child to listen to you? _____

- What types of discipline have you found most helpful to get your child to behave? _____

- Has your child ever seen a counselor or a therapist? Yes No
Name of counselor or therapist _____
What were the reasons for seeing a counselor? _____

Was it helpful? Yes No If yes, why? _____

If no, why not? _____

E. Coping:

- Besides your child's current diagnosis, has your child or family recently experienced any major changes, positive or negative (moving, separation, losses, birth of a sibling, etc.)? Yes No
If yes, please explain: _____

- Have you or anyone close to you experienced a major illness? Yes No
If so, please explain: _____

- What words have you used to explain your child's current illness to him/her? _____

- Has your child's illness had any effects on his/her feelings about himself/herself? Yes No

If yes, please describe: _____

5. Has your child's illness had any effect on the behavior of his/her siblings? Yes No

If yes, please describe: _____

6. Has your child's illness had any effect on the family as a whole? Yes No

If yes, please describe: _____

7. In general, how does **your child** relax, calm down or deal with stress?

Please check all that apply:

- | | | |
|--|---|----------------------------------|
| <input type="checkbox"/> Physical activity | <input type="checkbox"/> Reading | <input type="checkbox"/> TV |
| <input type="checkbox"/> Rocking/holding | <input type="checkbox"/> Meditation | <input type="checkbox"/> Working |
| <input type="checkbox"/> Jog/walk | <input type="checkbox"/> Relaxation exercises | <input type="checkbox"/> Prayer |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Talk to someone | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Playing | <input type="checkbox"/> Other _____ | |

8. Does your child have security objects? Yes No

If yes, please explain: _____

9. In general, how do **you** relax or deal with stress?

Please check all that apply:

- | | | |
|--|---|----------------------------------|
| <input type="checkbox"/> Physical activity | <input type="checkbox"/> Reading | <input type="checkbox"/> TV |
| <input type="checkbox"/> Rocking/holding | <input type="checkbox"/> Meditation | <input type="checkbox"/> Working |
| <input type="checkbox"/> Jog/walk | <input type="checkbox"/> Relaxation exercises | <input type="checkbox"/> Prayer |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Talk to someone | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Playing | <input type="checkbox"/> Other _____ | |

10. Do you feel comfortable asking additional questions about your child's condition from doctors? Yes No

11. Do you feel comfortable letting the medical team know when you are overwhelmed with information? Yes No

12. What do you think will be most difficult about your child's illness for you? _____

for your child? _____

for your family? _____

13. Are there people (close by) whom you can rely on for support? Yes No

If yes, who? _____

F. Family Mental Health

1. Have you or anyone in your family been treated for a major psychiatric illness? Yes No
If yes, who? _____
When? _____
Diagnosis? _____
2. Have you or anyone else in the family been treated and/or have problems with alcohol or substance abuse? Yes No
If yes, who? _____
When? _____
3. Have there ever been any concerns about domestic violence, physical or sexual abuse in your family? Yes No If yes, please explain? _____

4. Is there anyone in your family who you are particularly worried about now? Yes No
If yes, please explain? _____

G. Pain Experience

The following questions are about your child's response to pain:

1. How would you rate your child's sensitivity to pain?
Low Medium High Not applicable
Please explain: _____

2. How does your child act when he/she is suddenly hurt (ex. falls down)? _____

3. Has your child had painful medical procedures before? Yes No
If yes, please describe _____

4. Does your child or anyone else in your family use complementary therapies? Yes No
If yes, please describe: _____

5. Are you interested in learning more about complementary therapies? Yes No
If yes, please describe _____

H. Values/Belief System

1. Do you have a religious affiliation? Yes No If yes, what religion? _____
2. Is your religion a source of support for you and/or your child? Yes No

3. Are spiritual beliefs important in assisting you and your child during this time? Yes No

If yes, please describe: _____

4. Are there cultural and/or ethnic values or beliefs about health that are important to you?

Yes No Please explain: _____

I. Resource Needs

1. Do you have insurance? Yes No

2. Name of Insurance Company _____

3. Do you have transportation to and from clinic/TCH? Yes No

4. Do you have financial needs related to your child's treatment? Yes No

If yes, please describe: _____

5. Do you have a working phone? Yes No

6. Is there anything else you would like to let us know that will help us while working with your child and family? _____

