

Child Assessment

5 to 9 Years

Client File Overview:

(This Intake Package is to be completed by the Referral Worker. Please print all responses)

Date of Assessment: _____

Last Name: _____ Male: Female:

First Name: _____ Known as: _____

Birthdate: Year _____ Month _____ Day _____ Age: _____

Aboriginal Ancestry Yes No Aboriginal Information _____ On Reserve Yes No
(Band Name, Inuit, Métis, Aboriginal Community)

Status Number: _____ Care Card Number: _____
Very important to have both

Home Address: _____

City: _____ Province: _____

Postal Code: _____ Phone: _____

Full Name of Parents/Guardians: _____

Who is this child coming to KFDC with?

Mother/Father (incl. step parents) Single Parent Other Family Members
Foster Parent (MCFD, USMA) Foster Parent (Informal) Siblings (Incl. step and half)

Emergency Contact: (Please list a person who may be contacted in case of emergency)

Name: _____

Phone: _____ Relationship to Client: _____

Referral Agency: _____
Counsellor's Name: _____
Address: _____
Phone: _____ Cell: _____ Fax: _____
Email: _____

Section 1 of 8: General

1. Who is taking care of this child? _____
Biological parent _____ Single Parent _____ Other Family Member _____
Foster Parent (*Informal*) _____ Foster Parent (*USMA, MCFD*) _____
2. What are the family dynamics?
Parents together _____ Parents Separated _____ Blended family _____
Step Parent _____ Step Siblings _____ Multiple families _____

Section 2 of 8: Education

(Please check the highest level of education that has been completed)

Pre-school (*pre-kindergarten*)

Elementary (*kindergarten, Grades 1 – 6*)

1. Does this child have any difficulty reading? Yes No
2. Does this child have difficulty writing? Yes No
3. Will this child require any assistance with reading/writing? Yes No

Section 3 of 8: Cultural/Spiritual

1. Is this child involved in any cultural/spiritual activities? Yes No
Please explain: _____
2. Does this child have any Healthy Elders in their life (outside of immediate family)? Yes No
Please explain: _____
3. Does this child see Culture as being part of their life? Yes No
Please explain: _____
4. Is this child willing to participate in First Nation's cultural components such as: Sweat Lodge, daily Smudge, Pipe and other cultural ceremonies? Yes No
Please explain: _____

Client's Name: _____

Section 4 of 8: Pre Treatment Assessment

1. Is this child receiving counselling? Yes No

If "Yes" how many counselling sessions have been provided in the last three months?

If "Yes" please list the name and contact info this this counsellor: _____

2. What issues are currently being addressed in counselling? _____

3. Who will be providing follow-up counselling with this child after their departure from KFDC?

Name of counsellor doing follow-up: _____

4. Does this child have a post-treatment appointment set? Yes No

Date: _____

5. Have you discussed the reason that you are attending treatment with your child?

Yes No

Explain: _____

6. What other information could you provide to help us evaluate the client's need (i.e. significant challenges, disability issues, life events, family patterns etc.) _____

Section 5 of 8: Trauma related history assessment (completed with parent or guardian)

1. Has your child had a history of violent behavior? Yes No

If yes, please explain: (offender/victim, when, circumstances, dates, etc.) _____

2. Has this child experienced any type of trauma?

Physical Abuse Date: _____ if yes, please explain: _____

Sexual Abuse Date: _____ if yes, please explain: _____

Emotional Abuse Date: _____ if yes, please explain: _____

Verbal Abuse Date: _____ if yes, please explain: _____

Educational Abuse Date: _____ if yes, please explain: _____

Spiritual Abuse Date: _____ if yes, please explain: _____

Domestic Violence Date: _____ if yes, please explain: _____

Car Accident Date: _____ if yes, please explain: _____

Fire Date: _____ if yes, please explain: _____

Grief and Loss Date: _____ if yes, please explain: _____

Other Date: _____ if yes, please explain: _____

3. Are any of the above a concern while at KFDC? Yes No

4. Did you (the parent) attend residential school? Yes No

When? _____

How Long _____

Name and location of the residential school: _____

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5. Does your child know anything about your residential school experience? _____

6. Has your child experienced the loss of a relative or close friend? Yes No

If yes, how did this child know this person? _____

7. How did the loss occur?

- Natural Causes Disease (i.e. cancer) Suicide Abandonment
 Apprehension Violent/Accidental Death Arrest Substance misuse related

8. What other losses has this child experienced?

(e.g. Family pet, move, friend moving, etc.)

9. Has your child received counselling as a result of any of these experiences: Yes No

Explain: _____

10. Was the counselling beneficial to your child? Yes No

If yes, please explain: _____

11. Do you have any concerns of issues you wished addressed with your child while you are at KFDC? _____

Section 6 of 8: *Behavioural assessment (completed with parent or guardian)*

Please check any of the following behaviours that you have observed

1. Emotional

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Kind | <input type="checkbox"/> Loving | <input type="checkbox"/> Patient | <input type="checkbox"/> Joyful |
| <input type="checkbox"/> Loyal | <input type="checkbox"/> Courageous | <input type="checkbox"/> Generous | <input type="checkbox"/> Trustworthy |
| <input type="checkbox"/> Depressed/Sad | <input type="checkbox"/> Lacking Confidence | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Shy/Quiet |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> No emotion | <input type="checkbox"/> Anxious/Fearful | <input type="checkbox"/> Angry/Disruptive |

2. Physical

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Gentle | <input type="checkbox"/> Kind | <input type="checkbox"/> Healthy | <input type="checkbox"/> Active |
| <input type="checkbox"/> Orderly | <input type="checkbox"/> Peaceful | <input type="checkbox"/> Respectful | <input type="checkbox"/> Enthusiastic |
| <input type="checkbox"/> Fighting/Bullying | <input type="checkbox"/> Cruel to Animals | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Frequent Illness |
| <input type="checkbox"/> Secretive | <input type="checkbox"/> Toileting Issues | <input type="checkbox"/> Eczema | <input type="checkbox"/> Other |

3. Dietary

- | | | |
|---|---|---|
| <input type="checkbox"/> Good eating habits | <input type="checkbox"/> Poor eating habits | <input type="checkbox"/> Consumes lots of sugar |
| <input type="checkbox"/> Vomiting/Appetite Problems | <input type="checkbox"/> Eating too much | <input type="checkbox"/> Eating too little |

4. Sleeping patterns

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Excellent Sleep | <input type="checkbox"/> Moderate Sleep | <input type="checkbox"/> Very little Sleep | <input type="checkbox"/> Trouble going to sleep |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Night time vigilance | <input type="checkbox"/> Bedwetting |

5. Delinquent Behaviour

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> Lying/Cheating | <input type="checkbox"/> Stealing, B & E | <input type="checkbox"/> Vandalism | <input type="checkbox"/> Trouble going to sleep |
|---|--|------------------------------------|---|

6. Does your child have?

- | | | | |
|-----------------------|--|-------------------|--|
| Lots of Friends | <input type="checkbox"/> Yes <input type="checkbox"/> No | Younger Friends | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Few Friends | <input type="checkbox"/> Yes <input type="checkbox"/> No | Older Friends | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Problems with bullies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problems bullying | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Boyfriend/Girlfriend | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

7. What does your child do for recreation? _____

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8. Has your child ever had previous experience away from home? Yes No

Explain: _____

9. Is the Child being returned to the parents to come to KFDC? Yes No

Explain: _____

10. Is he or she comfortable with others? Yes No

11. How would you describe your parenting style?

Explain: _____

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Section 7 of 8: *Consent to attend treatment*

I give (Youth's Name, PLEASE PRINT _____) permission to attend Kackaamin Family Development Centre.

Parent/Guardian Signature

Date

Referral Worker's Signature

Date

Section 8 of 8: *Consent to release Confidential Information*

I (parent) _____ hereby request and permit KFDC staff to discuss any and all confidential information and assessments about my child with my referral worker listed below.

Child client's Name: _____

Signature of Parent: _____

Date: _____

Referral Worker's Name: _____

Organization/Agency's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Contact #: _____ Fax #: _____

Email Address: _____

Alternate Contact Person within your organization: _____

(The alternate contact person is for the confirmation or admission process only – the alternate contact will not be included in the release of confidential information prior to, during, or after treatment. The client may change the name of the person that receives the Discharge Summary at any time. It is up to the client to inform their referral worker of that change. N.B. this form is only applicable for one year after the date it is signed).

Client's Name: _____