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:

Name	Age	Relationship

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

Name	Age	Relationship

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):_____

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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	□	□	□	□
Energetic	□	□	□	□
Plays well with others	□	□	□	□
Plays well alone	□	□	□	□
Sad	□	□	□	□
Worries	□	□	□	□
Outgoing	□	□	□	□
Anxious	□	□	□	□

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Uncooperative	□	□	□	□

	Not at all	A little	A lot	N/A
Angry	□	□	□	□
Aggressive	□	□	□	□
Distractible	□	□	□	□
Loving	□	□	□	□
Happy	□	□	□	□
Imaginative	□	□	□	□
Controlling	□	□	□	□
Flexible	□	□	□	□
Independent	□	□	□	□

1. Have you ever been concerned about your child's behavior? If so, how?_____

   When?_____

2. What have you found to be the most effective way to get your child to listen to you?_____

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

4. 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:

1. 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:_____

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

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

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

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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:

□ Physical activity	□ Reading	□ TV
□ Rocking/holding	□ Meditation	□ Working
□ Jog/walk	□ Relaxation exercises	□ Prayer
□ Crying	□ Talk to someone	□ Nothing
□ Playing	□ 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:

□ Physical activity	□ Reading	□ TV
□ Rocking/holding	□ Meditation	□ Working
□ Jog/walk	□ Relaxation exercises	□ Prayer
□ Crying	□ Talk to someone	□ Nothing
□ Playing	□ 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? _____

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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 □

   _____

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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? _____

   _____

   _____

   _____

   _____

   _____

   _____

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