DASHOMETRICS, LLC
EMPOWERING PSYCHOLOGICAL TOOLS

YOUTH DIAGNOSTIC ADDENDUM

Client Name _____ **Age/DOB**_____

Therapist _____ **Date of Face to Face** _____

Sources of Information: ❍ Interview(s) of Client ❍ Review of previous ❍ Diagnostic Assessement
❍ Interview(s) with Others (Family/supports) ❍ Health Records Review ❍ Observations

Notes _____

PREGNANCY

Was the mother under a doctor's care? ❍ No ❍ Yes

Number of previous pregnancies/miscarriages: _____

Did the mother experience any of the following during the pregnancy?

❍ Maternal injury ❍ Prescription medications ❍ Toxemia/anemia ❍ Major illness ❍ Hospitalized
❍ Abnormal weight gain/loss ❍ Excessive vomiting ❍ Alcohol used ❍ Diabetes ❍ X-rays taken
❍ Cigarettes used ❍ High blood pressure ❍ Emotional problems ❍ Illegal/street drug use
❍ Other **Details for items checked above:** _____

_____

BIRTH

Was the child born in a hospital? ❍ No ❍ Yes If no, where? _____

Type of delivery: _____ Length of pregnancy: ❍ Term ❍ Other _____

Birth weight: ____ lbs ____ oz Length: ____ in

Complications during the birth and first two weeks of life? ❍ No ❍ Yes

Notes: _____

_____

DEVELOPMENT

At what age did the child do the following? ❍ Within normal limits to all

❍ Sit alone without support ❍ Roll over by self ❍ Crawl ❍ Walk alone without support
❍ Speak first words ❍ Put 2-3 words together ❍ Bladder trained during day ❍ Bladder trained at night

Was the child: ❍ breast-fed ❍ bottle-fed ❍ both Age when weaned: _____

Did bed-wetting/bed-soiling occur after toilet training? ❍ No ❍ Yes If yes, until what age? _____

Describe any actions taken (medical, therapeutic): _____

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DEVELOPMENT *(coniinued)*

Has this child experienced problems in any of the following areas:

Sleep	❍ No	❍ Yes	Excessive crying	❍ No	❍ Yes
Unclear speech	❍ No	❍ Yes	Difficulty learning to skip	❍ No	❍ Yes
Feeding/eating problems	❍ No	❍ Yes	Separating from parents	❍ No	❍ Yes
Under/over weight problems	❍ No	❍ Yes	Temper tantrums	❍ No	❍ Yes
Over/under active	❍ No	❍ Yes	Hearing/vision problems	❍ No	❍ Yes
Lead exposure	❍ No	❍ Yes	Dental concerns	❍ No	❍ Yes

Notes: _____

_____

FAMILY DISCIPLINE

Who is mainly in charge of discipline in the home? ❍ Mom(s) ❍ Dad(s) ❍ Both parents ❍ Other

Describe discipline techniques: (shouting, grounding, take away phone, early curfew, no sleepovers)

_____

_____

EDUCATIONAL HISTORY

Does/did this child attend: ❍ Head Start ❍ Preschool ❍ Kindergarten Current grade: _____

School attending: _____

Is the child currently experiencing any of the following school problems?

❍ Truancy ❍ Fighting ❍ Stealing ❍ Argues with teachers ❍ Refuses to do school work ❍ Stealing

❍ Suspended ❍ Expelled ❍ Transferred ❍ TIP (court) ❍ Changed schools repeatedly

Check the item that best describes the child in the following areas:

Attendance:	❍ Rarely absent	❍ Sometimes absent	❍ Often absent
Ability:	❍ Above average	❍ Average	❍ Below average
Relations with classmates:	❍ Above average	❍ Average	❍ Below average
Behavior:	❍ Above average	❍ Average	❍ Below average

Notes: _____

Has the child been tested for special education? ❍ No ❍ Yes

Notes: _____

FAMILY RELATIONS/CHILD STRENGTHS

Does the child participate in any community activities (mentor, YMCA, etc)? ❍ No ❍ Yes

Notes: _____

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FAMILY RELATIONS/CHILD STRENGTHS *(continued)*

Coping resources:

❍ Good worker	❍ Patient	❍ Assertive	❍ Good memory
❍ Makes good decisions	❍ Athletic	❍ Healthy	❍ Sense of humor
❍ Learns from mistakes	❍ Independent	❍ Responsible	❍ Honest
❍ Creative	❍ Cheerful/optimistic	❍ Patient	❍ Adaptable
❍ Smart	Notes: _____		

Social skills and support:

❍ Liked by adults	❍ Close with one or more adults	❍ Can compromise and share
❍ Has friends same age	❍ Respects others	❍ Appropriate friend choices
❍ Confides in friend(s)	❍ Cooperative	❍ Outgoing
❍ Caring	❍ Seeks support of parent	❍ Nurturing towards young childen
❍ Helpful, supportive	❍ Accepts comfort and guidance	❍ Expresses feelings
❍ Participates in hobbies/sports	Notes: _____	

_____

Self-esteem:

❍ Likes self	❍ Doesn't dwell on mistakes	❍ Cares about the future
❍ Feels capable/confident	❍ Cares about appearance	❍ Recognizes own strengths/skill

Notes: _____

_____

Other strengths:

What do you enjoy most about raising this child? _____

_____

What would you like this child to be when s/he grows up? _____

_____

_____

_____

_____ _____

Staff Signature Date Completed