Ansonia Public Schools

**SCHOOL SOCIAL WORK**

**Initial Assessment**

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case Manager: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homeroom Teacher: \_\_\_\_\_\_\_\_\_\_\_

**Parent was unavailable for the assessment.\_\_\_**\_\_\_

CONFIDENTIAL

1. **STUDENT IDENTIFYING INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Primary Language: |  |
| D.O.B.: |  | Ethnicity: |  |
| Sex: |  | Student Email: |  |
| School: |  | Student Cell: |  |
| Grade: |  |  |  |
| Place of Birth: |  |  |  |

Residence of Child Address: \_\_\_ Biological Parents \_\_\_\_ Adoptive Parent

\_\_\_\_Foster Parent \_\_\_\_Other

Is custody a concern? If “Yes,” please provide documentation.

Dominant Language of the Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the dominant language is something OTHER than English:

1. What language did the student start speaking first? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do both parents speak English and another language?\_\_\_ Yes \_\_\_\_No

If “No”: \_\_\_\_No, only Father \_\_\_\_No, only mother

3. Which language did the child begin speaking first? \_\_\_ English \_\_\_\_Other (specify)

4. Did the child learn to speak English from an older sibling? \_\_\_\_Yes \_\_\_ No

**II. FAMILY IDENTIFYING INFORMATION**

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Custody:\_\_\_ Physical \_\_\_\_Legal \_\_\_\_Visitation\_\_\_\_ No Contact

Mother’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Custody: \_\_\_\_Physical \_\_\_\_Legal \_\_\_\_Visitation\_\_\_\_\_No Contact

Father’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are parents living together? \_\_\_\_\_ Yes \_\_\_ No Are parents Married? \_\_\_\_ Yes \_\_\_\_ No

Separated? \_\_\_\_Yes \_\_\_\_ No Date: \_\_\_\_\_ Divorced? \_\_\_\_ Yes \_\_\_\_ No Date:\_\_\_\_\_\_

How many siblings does the child have?  **\_\_\_\_** Brothers **\_\_\_\_\_** Sisters

How many siblings live in the home? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Parent/Guardian and Siblings | D.O.B | Relationship to Student |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

Check all that apply.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Family Member Name | Difficulty with Learning | Receives/d Special Education Services | Reading | Writing | Spelling | Math |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |

**III. HOME COMPOSITION**

Significant Family Medical/Psychiatric Conditions:

Did you or anyone in the immediate family receive mental health or substance abuse treatment in the last year? \_\_\_\_ Yes  **\_\_\_\_** No

If so where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for Mental Health or Substance Abuse? \_\_\_\_\_ Yes **\_\_\_\_** No

If So How many times?\_\_\_\_\_\_\_ When and Where?\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medication for mental health needs? \_\_\_\_ Yes **\_\_\_\_** No

If so, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Changes in family (i.e. losses, moves, financial, deaths, Incarcerations):

Describe how you and your child interact, as well as how your child and his or her siblings interact with each other.

**Presenting Problems:**

What are your current concerns about your child?

When did you first notice the problem (age/grade)?

How has that problem affected his/her functioning?

Home?

School?

Community?

What makes it better?

What makes it worse?

**Pregnancy/Birth/Developmental:**

Length of pregnancy:

Birth weight:

Unusual conditions during pregnancy (i.e. use or exposure to medication, drugs, alcohol that you think may have impacted your child):

Were there any problems before, during, or immediately after your pregnancy? \_\_\_\_Yes **\_\_\_\_**No

If “*Yes,*” please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complications during labor and delivery:

Child’s condition at birth:

Did your child receive Birth-3 services?\_\_\_\_\_Yes **\_\_\_\_\_** No

Has your child ever had difficulty with: (Check all that apply)

|  |  |  |
| --- | --- | --- |
| Activity | In the Past | Ongoing |
| Coloring/Drawing |  |  |
| Using cutlery |  |  |
| Tying shoelaces |  |  |
| Puzzles |  |  |
| Legos |  |  |
| Dressing |  |  |
| Catching Balls |  |  |
| Throwing Balls |  |  |
| Stair Climbing |  |  |
| Cycle Riding |  |  |
| Remembering Nursery Rhymes |  |  |
| Coordination |  |  |
| Toilet Training |  |  |
| Bedwetting |  |  |
| Hyperactivity |  |  |
| Tantrums |  |  |
| Discipline |  |  |
| Anxiety |  |  |
| Withdrawn |  |  |
| Depression |  |  |
| Anger |  |  |

**The Age the Child:**

Walked:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Talked:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toilet trained: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Day or night time accidents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical:**

Primary Care Physician:

What, if any, medical problems does the child have (i.e. hearing, vision, speech):

Does your child appear to have any other physical/health problems including allergies? **\_\_\_\_\_**Yes \_\_\_\_No

If “*Yes,*” please explain:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is your child is under the care of a physician and/or taking prescription medications?

**\_\_\_\_** Yes \_\_\_\_No

If “*Yes,*” please explain:as needed for above: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are there any side effects to the medication that he/she is taking? \_\_\_\_Yes \_\_\_\_ No

If “*Yes,*” please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Concerns:

Surgeries/Hospital stay:

Lead Poisoning:

Head Injury/Trauma?

Loss of consciousness?

Bed Wetting:

History of Ear Infections: \_\_\_\_ Yes **\_\_\_\_** No

Ear Infections Ongoing? \_\_\_\_ Yes \_\_\_\_No

Approximately how many ear infections?

History of tubes in ears? \_\_\_\_ Yes **\_\_\_\_** No

If yes, how many times?

If yes, at what age(s)?

Ear infections stopped at what age?

History of Vision Issues: \_\_\_\_Yes **\_\_\_\_** No

Wears Glasses: \_\_\_\_Yes \_\_\_\_\_ No

If the child wears glasses, what is the concern?

**Psychiatric:**

Current Social Service Agencies involved (DCF, PCRC, Catholic Charities etc.): \_\_\_ Yes

\_\_\_ No

\_\_\_\_\_Past Involvement \_\_\_\_\_\_\_Client/Family Denies

Describe Involvement: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How many psychiatrists/doctor changes in the past five years:

Any psychiatric hospitalizations? Reason?

What gender does your child identify with?

Please check yes or no.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Social Anxiety (shy and/or afraid to be around others) |  |  |
| Remembering Past Traumas (frequent nightmares, intrusive and/or recurrent memories etc.) |  |  |
| Autism (social and language impairments, rigidity) |  |  |
| Psychosis (hearing voices, seeing things, paranoia, delusions) |  |  |
| Dissociation (feeling outside your body or things are not real, etc.) |  |  |
| Has your child ever harmed themselves intentionally? Attempted suicide? |  |  |

**Trauma Screening:**

Has the student been sexually abused?

Has the student been emotionally abused?

Has the student been physically abused?

Has the student witnessed or been exposed to abuse or violence toward others?

Has the student been exposed to community violence?

Has the student experienced disrupted attachment and/or multiple placements?

Has the student experienced the death of someone close to them?

Has the student been in or seen a very bad accident?

Has the student been attacked by a dog or any other animal?

Has the student experienced any other traumatic event? Please describe.

Are there any special, unusual, or traumatic circumstances that affected the student’s development? Please describe.

**Sleeping Patterns:**

Total hours of sleep per night: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Usual Sleep Schedule\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_** to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Concerns: | Current Problem | Change within the last 6 months |
| Difficulty Falling Asleep | Yes or No | Yes or No |
| Frequent awakening | Yes or No | Yes or No |
| Snoring | Yes or No | Yes or No |
| Restlessness/Movements | Yes or No | Yes or No |
| Early morning awakening | Yes or No | Yes or No |
| Nightmares | Yes or No | Yes or No |
| Not rested | Yes or No | Yes or No |

Does your child experience night terrors or nightmares? If so how often?

Does the child have his or her own room?

**Schooling**

Previous schools and years attended (starting with Preschool):

Are there any school attendance issues?

How many behavioral referrals does he/she have?

What are your child’s strengths?

What are your child’s weaknesses?

Check Yes or No. Has Your Child Ever:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Been Held Back a Grade |  |  |  |
| Previous or Current 504 plans/special education referrals/behavior plans? |  |  |  |
| Attended a Resource Room |  |  |  |
| Been Assigned to Remedial Reading Classes |  |  |  |
| Received Speech/Language Therapy |  |  |  |
| Been Tutored in School |  |  |  |
| Been Tutored out of School |  |  |  |
| Been Assigned to Special Education Classes |  |  |  |
| Received Perceptual Training |  |  |  |
| Attended a Special Day School |  |  |  |
| Attended a Special Residential School |  |  |  |
| Skipped a Grade |  |  |  |
| Attended a Program for the Gifted |  |  |  |

If attended a special school was it for:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Behavior issues |  |  |  |
| Emotional issues |  |  |  |
| Learning Disability |  |  |  |
| Language Disability |  |  |  |
| Physical Disability |  |  |  |

Has this child ever had serious difficulties with any of the following subjects in school?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Reading |  |  |  |
| Spelling |  |  |  |
| Handwriting |  |  |  |
| Composition |  |  |  |
| Mathematics |  |  |  |
| Science |  |  |  |
| Social Studies/History |  |  |  |
| Speech |  |  |  |
| Foreign Language |  |  |  |

**Dyslexia Checklists**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Does your child have difficulty with time management, anxiety and fear, or frustration and low self-esteem? |  |  |  |
| Was your child ever diagnosed with dyslexia by 3rd grade? |  |  |  |
| Would you consider your child a confident learner? |  |  |  |
| Is your child easily distracted by noise, activity, or visual clutter? |  |  |  |
| Does your child experience frustration, perfectionism, or perseveration when completing a task? For example, constant repetition of the same procedures until satisfied with their skills. |  |  |  |

Before the Child Started School:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Had trouble learning the alphabet, numbers, days of the week, colors, and shapes |  |  |  |
| Had trouble learning to spell and write his/her name |  |  |  |
| Had difficulty reciting the alphabet without singing the song |  |  |  |
| Had difficulty identifying the letters when presented at random |  |  |  |
| Had difficulty learning the sounds that letters make |  |  |  |

Once Enrolled in School

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Child spends more time than is appropriate/normal on homework |  |  |  |
| Child needs an extraordinary amount of help with homework |  |  |  |
| Child prefers to be read to rather than reading to you |  |  |  |

Family History of Dyslexia:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Father |  |  |  |
| Mother |  |  |  |
| Brother |  |  |  |
| Sister |  |  |  |

If *“Yes,”* who diagnosed the dyslexia? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Early Years/Elementary School Warning Signs:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Talked later than his/her siblings or peers |  |  |  |
| Used "baby talk" that continued past the normal stage |  |  |  |
| *Had difficulty pronouncing words, i.e., "busgetti" for "spaghetti," "mawn lower" for "lawn mower"* |  |  |  |
| Did not enjoy listening to books with rhyme |  |  |  |
| Unable to recite popular nursery rhymes |  |  |  |
| *Unable to recall the right word. Child may "talk around the word." ("Um, um, um…I forgot.")* |  |  |  |
| Had difficulty learning/saying a new vocabulary word |  |  |  |
| *Overuses vague words like "stuff" or "that thing"* |  |  |  |
| Hard to follow the conversation because the sentences are filled with pronouns or words lacking in specificity. (i.e., *"The things were all mixed up, but I got the stuff anyway."*) |  |  |  |
| Has difficulty telling and/or retelling stories in correct sequence |  |  |  |
| Able to easily express himself with correct articulation |  |  |  |

Middle School Warning Signs:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Struggles with reading and spelling |  |  |  |
| Confuses the order of letters, such as writing "left" instead of "felt" |  |  |  |
| Has trouble remembering facts and numbers |  |  |  |
| Has difficulty gripping a pencil |  |  |  |
| Has difficulty using proper grammar |  |  |  |
| Has trouble learning new skills and relies heavily on memorization |  |  |  |
| Gets tripped up by word problems in math |  |  |  |
| Has a tough time sounding out unfamiliar words |  |  |  |
| Has trouble following a sequence of directions |  |  |  |

High School Warning Signs:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Struggles with reading out loud |  |  |  |
| Doesn’t read at the expected grade level |  |  |  |
| Has trouble understanding jokes or idioms |  |  |  |
| Has difficulty organizing and managing time |  |  |  |
| Struggles to summarize a story |  |  |  |
| Has difficulty learning a foreign language |  |  |  |

**Social:**

Does your child have friends outside of school?

What is the age group with which your child prefers to associate? Is this a reflection of the neighborhood or a change from past preference?

What activities/sports does your child participate in? Please describe the student’s peer relationships:

[ ] a leader with peers [ ] several positive friendships [ ] vulnerable to negative peer influences not sure

[ ] often teased and rejected [ ] limited-1 or 2 friends, occasional involvement

[ ] seldom interacts with friends [ ] aggressive when interacting with peers

IV. STUDENT INTERVIEW

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies/interests?

What is your favorite thing to watch on T.V.?

How old are your friends?

How often do you use social media? everyday Which types?

Do you have a T.V. or computer in your bedroom?

How do you get along with your parents/siblings?

Do you have access to weapons?

Have you ever smoked cigarettes/ecigarettes? If so, how often? If so, when did you begin?

Do you vape or use a vapor device?  If so, how often? If so, when did you begin?

Have you ever used drugs and/or alcohol? If so how often? If so, at what age did you begin?

Are you sexually active and, if so, when did you become sexually active?

What gender do you identify with?

Do you experience night terrors?

Have you witnessed or experienced emotional, physical, and/or sexual abuse?

What was your happiest time?

What was your saddest time?

What was your scariest time?

Do you worry about anything at home?

Do you worry about anything at school?

Do you like school?

Is there anything that frustrates you about school?

What is your most difficult subject?

If you could change one thing about yourself what would it be?

What do you want to be when you grow up?

What changes need to be made to help you be more successful?

If you had three wishes what would they be? 1) 2) 3)

Is there a grown up in school who you feel close to?

Have you ever thought about hurting yourself or others? If so, in what ways?

Have you ever acted on those thoughts?

Have you ever hurt an animal and, if so, how and why?

Have you ever attempted suicide?

Dyslexia Checklist for Students (Reading, Writing, Indicators, Strengths):

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Unsure |
| Confuses letters that look similar: d-b, u-n, m-n? |  |  |  |
| Confuses letters that sound the same: v,f,th? |  |  |  |
| Reverses words: was-saw, now-won? |  | **x** |  |
| Transposes words: left-felt? |  | **x** |  |
| When reading, has difficulty in keeping the correct place on a line and frequently loses his/her place? |  | **x** |  |
| Reads correctly but does not understand what s/he is reading? |  | **x** |  |
| Can write what s/he reads? | x |  |  |
| Knows which hand s/he writes with? | **x** |  |  |
| Is s/he easily distracted and has poor concentration? | **x** |  |  |
| Shoe s/he squint the eyes while reading or copying things from the board? |  | x |  |
| Does s/he have hearing problems? |  | **x** |  |
| Does s/he get confused between: left/right, over/under? |  | **x** |  |
| Does s/he have problems telling the time? |  | **x** |  |
| Does s/he have problems with tying shoelaces, etc.? |  | **x** |  |
| Does s/he have short-term memory problems relating to printed words and instructions? |  | x |  |
| Does s/he have particular difficulty copying from a blackboard? |  | **x** |  |
| Does s/he have confusion with mathematical symbols (plus/minus, etc.) |  | **x** |  |
| Does s/he have inability to follow more than one instruction at a time? |  | x |  |
| Does s/he have sequencing difficulties in reciting the alphabet? |  | x |  |
| Does s/he have sequencing difficulties in reciting the days of the week? |  | x |  |
| Does s/he have sequencing difficulties in reciting the months of the year? |  | x |  |
| Does s/he have sequencing difficulties in reciting numbers in multiplication tables? |  | x |  |
| Is s/he clumsy or has poor body coordination? |  | **x** |  |
| Does s/he have good verbal skills - like talk or tell stories? | x |  |  |
| Is s/he good in drawing or painting or sketching? | x |  |  |
| Is s/he good with his/her hands, for e.g. fixing or repairing things, like to work with tools, etc? | x |  |  |
| Is s/he always full of ideas about various things? | x |  |  |
| Does s/he like to create things? | x |  |  |
| Does s/he ask a lot of questions? | x |  |  |