

# Risk Assessment

Name:

Chart No.:

DOB:

Program:

Yes	No	Urk	Assessment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>1. Is this child a danger to him/herself or others?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>has attempted suicide, made suicidal gestures, or expressed suicidal ideation</i></li> <li><input type="checkbox"/> <i>assaultive to other children or adults</i></li> <li><input type="checkbox"/> <i>reckless and routinely puts self in dangerous situations</i></li> <li><input type="checkbox"/> <i>attempted to or has sexually assaulted or molested other children</i></li> <li><input type="checkbox"/> <i>engaged in self-mutilation</i></li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>2. Does this child have a history of neglect, physical or sexual abuse or has he/she been exposed to violent behavior in his/her home?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>has been subject to or has witnessed physical abuse</i></li> <li><input type="checkbox"/> <i>has been subject to neglect</i></li> <li><input type="checkbox"/> <i>has been subject to or has witnessed sexual abuse</i></li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>3. Does this child have behaviors that are so difficult that his/her current living or educational situation is in jeopardy?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>behaviors are chaotic or disruptive</i></li> <li><input type="checkbox"/> <i>has daily verbal outbursts</i></li> <li><input type="checkbox"/> <i>refuses to follow basic rules</i></li> <li><input type="checkbox"/> <i>does not respond to limit-setting or other discipline</i></li> <li><input type="checkbox"/> <i>constantly challenges authority of adults or attempts to undermine authority of caregiver with other children</i></li> <li><input type="checkbox"/> <i>requires constant direction and supervision in all or most activities</i></li> <li><input type="checkbox"/> <i>requires total attention of caregiver and is overly jealous of caregiver's other relationships</i></li> <li><input type="checkbox"/> <i>wanders the house at night</i></li> <li><input type="checkbox"/> <i>is regularly truant from school</i></li> <li><input type="checkbox"/> <i>has significant sleeping problems</i></li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>4. Does the child exhibit unusual, bizarre or psychotic behaviors?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>history or pattern of fire setting</i></li> <li><input type="checkbox"/> <i>cruelty to animals</i></li> <li><input type="checkbox"/> <i>masturbates compulsively and/or publicly</i></li> <li><input type="checkbox"/> <i>hears voices or responds to other internal stimuli (including alcohol or drug induced)</i></li> <li><input type="checkbox"/> <i>consistently repeats words, sounds or phrases; emits unusual noises or sounds</i></li> <li><input type="checkbox"/> <i>smears feces or engages in other activities that exhibits lack of repulsivity</i></li> <li><input type="checkbox"/> <i>markedly flat affect, loose associations or flight of ideas</i></li> <li><input type="checkbox"/> <i>experiences significant paranoia</i></li> <li><input type="checkbox"/> <i>bizarre fixations</i></li> <li><input type="checkbox"/> <i>hoards and/or hides food</i></li> <li><input type="checkbox"/> <i>eats or drinks substances that are not food</i></li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>5. Does the child need psychotropic medication?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>need is immediate</i></li> <li><input type="checkbox"/> <i>needs medication evaluation</i></li> <li><input type="checkbox"/> <i>currently stable on psychotropic medications</i></li> </ul>

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>6. Does the child have problems with social adjustments?</b> <input type="checkbox"/> regularly involved in physical fights with other children or adults <input type="checkbox"/> verbally threatens people <input type="checkbox"/> purposely damages possessions of self or others <input type="checkbox"/> runs away from home or adult supervision <input type="checkbox"/> has been caught stealing or has been known to steal on more than one occasion <input type="checkbox"/> frequently lies in order to avoid consequences or to look good among peers <input type="checkbox"/> confined due to serious law violations <input type="checkbox"/> does not seem to feel guilt after misbehavior <input type="checkbox"/> consistent pattern of negative, hostile, or defiant behavior <input type="checkbox"/> does not form bond or attachment to caregiver or other appropriate adult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>7. Does the child have problems making and maintaining healthy relationships?</b> <input type="checkbox"/> unable to form positive relationships with peers <input type="checkbox"/> provokes other children to victimize him/her. <input type="checkbox"/> involved with gangs or expresses the desire to be <input type="checkbox"/> engages in sexual behavior that puts him/her at risk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>8. Does this child have problems with personal care?</b> <input type="checkbox"/> enuretic or encopretic (subject to age of child) <input type="checkbox"/> refuses or is unable to tend to personal hygiene
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>9. Does this child have significant impairment in functional development?</b> <input type="checkbox"/> child's academic performance at school is impaired <input type="checkbox"/> significant delays in language, especially expressive and receptive skills <input type="checkbox"/> under socialized and incapable of managing age appropriate tasks (e.g. play catch, make change, participate in team play)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>10. Does this child have significant problems managing his/her feelings?</b> <input type="checkbox"/> severe temper tantrums; screams uncontrollably; cries inconsolably <input type="checkbox"/> withdrawn and uninvolved with others <input type="checkbox"/> unable to tolerate normal separation from significant others <input type="checkbox"/> worries excessively and/or is hypervigilant <input type="checkbox"/> compulsively preoccupied with minor annoyances <input type="checkbox"/> regularly expresses feelings of worthlessness or inferiority <input type="checkbox"/> exhibits excessive grandiosity <input type="checkbox"/> frequently appears sad or depressed <input type="checkbox"/> significant issues relating to food
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>11. Does this child have problems with attention and/or hyperactivity?</b> <input type="checkbox"/> attention <input type="checkbox"/> hyperactivity

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>12. Does this child have a history of inpatient or outpatient psychiatric care, or is he/she taking prescribed psychotropic medications?</b></p> <p><input type="checkbox"/> <i>has been in inpatient psychiatric care</i></p> <p><input type="checkbox"/> <i>currently being seen in outpatient mental health treatment</i></p> <p><input type="checkbox"/> <i>has previously been seen in outpatient mental health treatment</i></p> <p><input type="checkbox"/> <i>currently taking psychotropic medication</i></p> <p><input type="checkbox"/> <i>has taken psychotropic medications in the past</i></p> <p><input type="checkbox"/> <i>medication prescribed but is not being taken as directed</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>13. Does the child have a history of using or exposure to drugs and alcohol?</b></p> <p><input type="checkbox"/> <i>regularly uses drugs and/or alcohol</i></p> <p><input type="checkbox"/> <i>past history of substance abuse</i></p> <p><input type="checkbox"/> <i>family has history of substance abuse</i></p> <p><input type="checkbox"/> <i>exposed to drugs and/or alcohol in utero</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>14. Does the child have a significant medical history or current problems with physical and or dental health?</b></p> <p><input type="checkbox"/> <i>barriers to medical/dental services</i></p> <p><input type="checkbox"/> <i>medical condition(s)</i> _____</p> <p><input type="checkbox"/> <i>dental condition(s)</i> _____</p> <p><input type="checkbox"/> <i>seizure disorder</i></p> <p><input type="checkbox"/> <i>pregnancy</i></p> <p><input type="checkbox"/> <i>significant weight gain or loss</i></p> <p><input type="checkbox"/> <i>behaviors that place the child at risk for health related issues ( e.g., sexual activity, drug use, smoking)</i></p> <p><input type="checkbox"/> <i>exhibiting side effects from psychotropic medication (e.g. dry mouth, dizziness, tremors, sedation)</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>15. Does the family have sufficient means to meet the child's basic needs?</b></p> <p><input type="checkbox"/> <i>Does the family have sufficient funding/insurance to cover the expenses of the child's medica/dental needs?</i></p> <p><input type="checkbox"/> <i>Does the family have sufficient means for transportation to meet the child's needs, i.e., school, medical appointments, day care, etc.?</i></p> <p><input type="checkbox"/> <i>Does the family meet the child's basic needs for food, clothing, shelter with electricity and running water?</i></p> <p><input type="checkbox"/> <i>Does the home have minimum furnishings, ie,, beds, dining table, etc...</i></p> <p><input type="checkbox"/> <i>Is the home and outside premises clean?</i></p> <p><input type="checkbox"/> <i>Does the family have friends or relatives that provide additional support or a network?</i></p>

Comments:

Date \_\_\_\_\_ Signature \_\_\_\_\_ Name (printed) \_\_\_\_\_

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