CAMHS Community Initial Assessment

Child/Young Person's Details	
Name:	**Address:**
Sex:	
Date of Birth:	
Contact No.:	
Nationality:	
School/Education Provider:	

Parent(s)/Guardian (s)Details	
Name:	**Address:**
Contact No.:	

Name:	**Address:**
Contact No.:	

CAMHS Details	
CAMHS Team:	**Consultant Psychiatrist:** Dr.

Assessment Details	
Assessment Location:	**Date of Assessment:**
Family/Guardian Present: *(Note reasons if a parent is not present)*	**Format of Assessment:** ☐ Face-to-Face ☐ Virtual (Video) ☐ Telephone ☐ Hybrid (in person and virtual) ☐ Other (please specify):

Consent forms signed by parent/guardian	☐ Yes ☐ No, if No give details:
Introduction to CAMHS and explanation of assessment process	☐ Yes ☐ No, if No give details:
Limits of confidentiality – including risk and child protection (Children's First)	☐ Yes ☐ No, if No give details:
Attendance Policy	☐ Yes ☐ No, if No give details:
Data Protection explained	☐ Yes ☐ No, if No give details:
Consent obtained from Parent(s)/Guardian(s)	☐ Yes ☐ No, if No give details:

Referral Information:	
Referral Source:	**Date of Referral:**
Reason for Referral:	

Professional help/Intervention received to date

Please list any professionals or services currently or previously involved with the child/young person and/or family (e.g. TUSLA, GP, Barnardos, school support, NEPS, psychologist, social work, SLT, OT, CDNT, private therapy).

Name	Profession	Organisation	Contact Number	Currently Involved
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Tusla involvement, ☐ Yes ☐ No, if No give details:

Family/Household Composition:		
Detail	**Age**	**Occupation/School**
Parent/Guardian		
Parent/Guardian		
Siblings		
Others living in the home		

Presenting Concerns
Parents/Guardian's view of difficulty/concern *Who first noticed a concern or problem?*
Parental Hopes/Expectations *What is the parent(s)/guardian(s) hoping for from this referral or CAMHS involvement?*
Young Person's view of difficulty/concern

Young person Hopes/Expectations

Can You Describe a Typical Day?

Prompts: appetite, sleep, interest in activities, social functioning, current friendships, school

Screening of symptoms for Mental Health Disorders
Please consider the following: *How often they happen (frequency), How bad they are when they happen (intensity, 1–10 scale), How long they last (duration), Where they occur (e.g., home, school, public), Where they do not occur (any exceptions)*
Depression *Prompts: low mood, irritability/anger, lack of interest, sleep, appetite, concentration, enjoyment, self-worth, guilt, energy, hopelessness*
Suicidality *Prompts: suicidal ideation, thoughts of self-harm, previous suicide attempts/self-harm (details)*
Anxiety *Prompts: Panic attacks (including physical symptoms), separation anxiety, school refusal, social anxiety, specific phobias, generalised anxiety, OCD (including intrusive thoughts and compulsions), PTSD (traumatic events - recurrent thoughts, flashbacks, avoidance, nightmares, hypervigilance)*
Psychosis *Prompts: Hallucinations, Delusions, Paranoid ideation*

Emotion dysregulation

Prompts: Marked fluctuation of mood, labile mood, pseudo hallucination, emptiness

Mania

Prompts: elated/expansive mood, decreased need for sleep, increased goal directed activity, racing thoughts

Feeding and Eating

Prompts: What do you eat on a typical day? Variety of intake, concerns around weight and shape, fear of fatness, loss of weight, loss of menstrual periods/libido, body image distortion, bingeing weight loss methods, e.g. laxatives/purging/excessive exercise

How are the difficulties currently managed?

Please describe what you do when the difficulties occur and how you respond.

What works?

Include anything that seems to calm or support them — routines, praise, strategies, etc.

Family Composition/Genogram

Genogram symbols to be included as legend

Current Living Arrangements:

Are parents married, cohabiting, separated, divorced? What is the current access or custody arrangements (if applicable)?

Family History of Difficulties:

Include any family history of developmental, communication, mental health, or physical health difficulties, addiction, domestic violence, intellectual disability any identified neurodivergence including ADHD, Dyslexia, Autism

Current or Previous Significant Life Events/Stressors:

Any major life events or ongoing stressors affecting the family (e.g., illness, finances, bereavement, housing)?

Who is the child/young person close to?

Please name any family members or others who are important to them (siblings, grandparents, carers, etc.).

Family Support Systems:

Do you have support from extended family, friends, services, or others? Is there opportunity for respite or breaks?

Parent(s)' Own Experience Growing Up:

If relevant, please describe anything from the parent(s)' background that might help us understand your family or parenting style.

Developmental History

Please include as much detail as possible in the areas below:

Pregnancy and Birth:

Any concerns during pregnancy? Drugs/alcohol/prescribed medication during pregnancy, gestation length, birth weight, type of delivery, complications post birth. (e.g., prematurity, NICU stay)

Postnatal Period:

Feeding, sleeping, bonding, early responsiveness, temperament, difficulty separating from parents, post-natal depression

Feeding and Eating:

Any difficulties with feeding (e.g., weaning, food refusal, sensory preferences)?

Sleeping Patterns:

Any difficulties with falling asleep, staying asleep, or sleep routine?

Motor Milestones:

When did your child sit, crawl, walk? Any concerns with coordination, balance, or fine/gross motor skills?

Speech, Language, and Communication:

Babbling, first words, language development, understanding, expressive language, social communication preferences for eye contact, use of gestures

Self-care Skills:

Toileting, dressing, hygiene, independence for age

Sensory Sensitivities or Ritualistic Behaviours:

Reactions to noise, textures, light, etc.; repetitive or ritualistic behaviours

Social Skills, Play and Friendships:

How does your child relate to others? Play as a child, e.g. imaginative, turning taking, rules/fairness. Initiate and maintain friendships? Any difficulties in social interaction?

Other Important Life Events:

e.g., separations, traumas, abuse, hospital admissions, bereavement, or other significant events

Include Adolescent History (if relevant)

Drug and alcohol history include history of smoking, vaping, alcohol or illicit substance use. Frequency of use, history of intoxication, symptoms of addiction and negative sequelae from use.

Psychosexual History

Technology Use

Phone, screen, gaming and social media use. What social media sites are used, history or actively accessing pornography, experience of cyber bullying, inappropriate online contacts. Frequency and duration of use and parental supervision

School Information

Schools Attended (including pre-school/Montessori/play school):

Please list all schools attended, in order, with dates if known.

Difficulties Separating or Transitioning to school?

Difficulties with school attendance?

Academic Progress:

Has your child made expected academic progress? Are there any areas of difficulty (e.g., literacy, numeracy, concentration)?

Concerns Raised by Staff or Teachers:

Have teachers expressed concerns about your child's behaviour, attention, emotional wellbeing, or learning? History of suspension/ expulsion?

Current and Previous Additional Educational Supports: Current/Past	
SNA support	Resource teaching
Special class	Special school
Autism Unit	NEPS Involvement, including cognitive assessment
Other:	
Please describe the nature and reason for any supports:	

History of Bullying or Being Bullied:
Parental and school response, type of bullying, e.g. verbal/physical
Abuse or Neglect Prompts: Physical/Sexual/Emotional

Medical History

Please include any known illnesses, hospitalisations, operations, allergies, or current medications. Hearing and vision check, menstruation, consider baseline weight/height, vaccinations

Presentation/Observation/Mental State

Please describe any relevant observations from your contact with the child or young person. Include appearance, engagement, mood, affect, behavior, risk (e.g., suicidal thoughts or self-harm), psychotic symptoms (if any), insight, and motivation.

Observation of interaction (+/- play) with caregivers and clinician:

Appearance and behavior:

(weight, height, dress, hygiene/grooming, rapport, eye-contact, psychomotor activity, co-operation, posture, abnormal movements, objects)

Speech, language and communication:

(tone, rate, rhythm, fluency, content, quantity, articulation, spontaneous, reciprocal, non-verbal)

Mood

(subjective, objective, rating e.g. euthymic, irritable, depressed, anxious, elated)

Affect

(range – broad/constricted/labile; reactivity – reactive/blunted/flat; appropriate/congruent)

Risk

(to self, from others, to others e.g. deliberate self-harm, suicidality, homochirality)

Thought

(stream e.g. racing; form e.g. coherent, logical; content e.g. obsessions, compulsions, over-valued ideas, delusions; possession e.g. insertion/withdrawal/broadcasting)

Perception/Hallucination

(type, pseudo/true, quality, detail, command, depersonalization, de-realization, passivity phenomena)

Cognition

(orientation, attention, memory)

Insight

(intact, partial, poor)

Protective Factors
What are the strengths and supports within the family? What does the child/young person do well? What do family members or others do that is helpful or supportive?

Child's Strengths
Please describe the child or young person's hobbies, interests, talents, friendships, and any involvement in sports, clubs, or other activities.

Other Relevant Information
Is there anything else you feel is important for CAMHS to know at this stage?

Formulation/Clinical Summary
Please summarise the key clinical picture. Include the presenting difficulty, relevant context, possible contributing (predisposing), triggering (precipitating), and maintaining (perpetuating) factors.
Interim Care Plan:

Name:	**Signature:**
Discipline:	**Date:**

Name:	**Signature:**
Discipline:	**Date:**