CHILD/ADOLESCENT BIOPSYCHOSOCIAL

IDENTIFYING INFORMATION:

Date of Initial Assessment: _____

Name of child _____ Sex: (M) ____ (F) _____

Birth date _____Place of birth_____ Age _____

Address_____

Race/Ethnicity(optional)_____

Referral Source: _____

Chief concern about your child: _____

Other concerns: (check all that apply):

__Very unhappy	__Impulsive	__Fire setting
__Irritable	__Stubborn	__Stealing
__Temper outbursts	__Disobedient	__Lying
__Withdrawn	__Infantile	__Sexual trouble
__Daydreaming	__Mean to others	__School performance
__Fearful	__Destructive	__Truancy
__Clumsy	__Trouble with the law	__Bed wetting
__Overactive	__Running away	__Soiled pants
__Slow	__Self-mutilating	__Eating problems
__Short attention span	__Head banging	__Sleeping problems
__Distractible	__Rocking	__Sickly
__Lacks initiative	__Shy	__Drug/Alcohol use
__Undependable	__Strange behavior	__Phobic
__Peer conflict	__Strange thoughts	__Suicidal talk

Please explain checked items:

_____

_____

How long have these problems occurred?

_____

_____

What occurred or changed that prompted you to seek therapy at this time?

_____

_____

Has your child been in therapy before? __Yes __No
If yes, please explain

_____

_____

What are your expectations of your child?

_____
_____
_____

What changes would you like to see in your child?

_____
_____
_____

What changes would you like to see in yourself? In your family?

_____
_____
_____

CURRENT FAMILY SITUATION:

Parent 1 name: _____

Relationship to child (please circle one) biological parent/adoptive parent/relative/step parent/foster parent

Address _____

Occupation_____

Education_____ Birthdate_____

Parent 2 name:_____

Relationship to child (please circle one) biological parent/adoptive parent/relative/step parent/foster parent

Occupation_____

Education_____ Birthdate_____

Marital status of parents (please circle one) Married/Separated/Divorced/Widowed

If child is adopted, please indicate source:_____

Date of adoption _____ Child's age at time of placement _____

Reason and circumstances:

_____
_____

What has your child been told about his/her adoption?

_____
_____

LIVING ARRANGEMENTS:

Number of moves in child's life_____ Places _____ Dates _____

Present Home (please circle all applicable) rent/own/house/apartment/other _____

Does your child share a room with anyone else? __Yes __No

If yes, with whom? _____

If no, how long has he/she had own room? _____

Did your child ever live away from the family? __Yes __No
Explain: _____

What are the major family stresses at the present time, if any?
_____
_____

BROTHERS and SISTERS: (indicate if step-brothers or step-sisters)

Name_____Age_____Sex_____Living at home Y___ or N___
Name_____Age_____Sex_____Living at home Y___ or N___
Name_____Age_____Sex_____Living at home Y___ or N___
Name_____Age_____Sex_____Living at home Y___ or N___
Name_____Age_____Sex_____Living at home Y___ or N___

Other members of household (age/sex/relationship to child/other important information)
_____
_____

Child and family history of:

Drug and/or alcohol problems: _____
Mental Health problems: _____
Self-Destructive behaviors: _____
Legal issues: _____

CHILD HEALTH INFORMATION:

Please list any medical issues your child is currently experiencing or experienced previously
_____
_____

Has your child ever been hospitalized __Yes __No
If yes, please explain _____

Current or prior medications (if applicable) _____

Name of Primary Care Physician _____

SOCIAL/DEVELOPMENTAL HISTORY:

Were there any problems during childbirth or early childhood that affected intellectual, social or emotional development and meeting of milestones?

_____
_____
_____

Describe your child's relationships with siblings and peers

_____
_____

Describe special habits, fears, or idiosyncrasies

_____
_____

Describe any special interests or hobbies your child has (art, music, crafts, outdoor activities, sports, church)

_____
_____
_____

EDUCATIONAL HISTORY:

Current school attending and grade level_____

Does your child have an IEP? __Yes __No
If yes, what is your child's classification? _____

Does your child have a 504 Plan? __Yes __No
If yes, please explain _____

Types of classes your child attends (please circle all that apply)
mainstreamed/resource room/self-contained/out of district school placement/other
_____

Did your child repeat or skip a grade? __Yes __No
If yes, please explain
_____

Please explain any other concerns you have about your child that were not addressed above

_____
_____
_____
_____
_____

PARENT QUESTIONNAIRE

Date: _____

Name of child:_____

Name of parent: _____

Answer all of the questions by indicating the degree of the problem.
Write **"N" for never, "S" for sometimes, or "0" for often** in front of the number for each question.

__ 1. Picks at things (nails, fingers, hair clothing)
__ 2. Talks back to authority figures (attitude)
__ 3. Has problems with making or keeping friends
__ 4. Excitable, impulsive
__ 5. Wants to run things
__ 6. Sucks or chews (thumb, clothing, blankets, etc.)
__ 7. Cries easily/often
__ 8. Emotionally reactive
__ 9. Has a chip on shoulder
__10. Tendency to daydream
__11. Difficulty learning
__12. Always squirming, restless, and moving around
__13. Experiences fear and anxiety in new situations/meeting new people
__14. Breaks things/destructive
__15. Lies, makes up stories
__16. Does not follow rules
__17. Gets into trouble more than peers
__18. Shy and does not assert self
__19. Has problems with speech (stuttering, hard to understand, baby talk)
__20. Denies mistakes and is defensive
__21. Blames other for mistakes
__22. Steals
__23. Argumentative
__24. Disrespectful
__25. Pouts and sulks
__26. Obeys rules but is resentful
__27. When hurt or angered by someone, holds a grudge
__28. Develops stomachache or headache when stressed
__29. Worries unnecessarily
__30. Does not finish tasks
__31. Emotionally sensitive and easily hurt
__32. Bullies others
__33. Cruel and insensitive

Additional Comments:
_____
_____
_____

ADOLESCENT SELF-ASSESSMENT:
CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU)

__ Depression
__ Low energy
__ Low self-esteem
__ Poor concentration
__ Hopelessness
__ Worthlessness
__ Guilt
__ Sleep disturbance (more/less}
__ Appetite disturbance (more/less)
__ Thoughts of hurting yourself
__ Thoughts of hurting someone
__ Socially withdrawal
__ Sadness/loss
__ Stress
__ Anxiety/panic
__ Heart pounding/racing
__ Chest pain
__ Trembling/shaking
__ Sweating
__ Chills/hot flashes
__ Tingling/numbness
__ Fear of dying
__ Fear of going crazy
__ Nausea
__ Phobias
__ Obsessions/compulsive behaviors
__ Thoughts racing
__ Easily agitated
__ Excessive behaviors {spending, gambling)
__ Delusions/hallucinations
__ Not thinking clearly/confusion
__ Feeling that you are not real
__ Feeling that things around you are not real
__ Lose track of time
__ Unpleasant thoughts won't go away
__ Anger/frustration
__ Easily agitated/annoyed
__ Defies rules
__ Blames others
__ Excessive use of drugs and/or alcohol
__ Excessive use of prescription medications
__ Blackouts
__ Physical abuse issues
__ Sexual abuse issues
__ Other problems/symptoms: _____

Have you previously been in therapy: __Yes __ No

Any Prior hospitalizations: __Yes __No Reason_____