Client/Child's Name_____

CHILDREN & ADOLESCENT BIOPSYCHOSOCIAL HISTORY & ASSESSMENT
(For our clients under the age of 18-years-old)

*Please complete to the best of your ability the information below that asks questions about you or the child you are seeking services for.

SECTION 1: GENERAL INFORMATION:

Name of person who is completing this form: _____Relationship to client/child: _____

Client/Child's Name:_____ Today's Date:_____

Address:_____
City:_____ State:_____Zip Code:_____
How long has the child lived at this address:_____ Phone Number: _____

Client/Child's D.O.B.:_____ Gender: Male / Female Client/Child's SS#:_____

Client's Biological Mother's Name:_____
Client's Biological Father's Name: _____

Is there a custody agreement for the child you are seeking treatment for? If yes, please explain:
_____
Who has legal rights of the child you are seeking treatment for?
_____

If the child does not live with his/her biological mother or father, please complete the following information:
Primary Guardian(s) Names: _____
Primary Guardian(s) Address: _____
Primary Guardian(s) Telephone Number(s): _____

Who should be contacted if there is an emergency?

Emergency Contact's Name_____

Address_____

Phone Number_____

Relationship to Client_____

Who referred client/child for services?: □ Family member □ Friend □ Doctor □ Insurance Agency □ Phone Book □Internet
□ Other _____

Presenting Problem/Recent Stressor(s) - What are the main reasons that you are seeking services for client/child at this time?
_____
_____
_____

Briefly describe how you hope that services through this agency may help you with your child:
_____
_____
_____

Client/Child's Name_____

Treatment Assignment Info (preferences are not guaranteed, but are helpful for our staff):

Do you have a preference as far as the therapist's gender for your child? □ Male □ Female □ Does not matter

Are there any other preferences regarding therapist/therapy for your child?
_____

What day/days or time of the day work best for you regarding scheduling future appointments? (Weekends/Evenings are not guaranteed)
_____

SECTION 2: CHIEF COMPLAINTS

Place a check mark next to all symptoms below that help explain problems that your child is experiencing at the present time.

- □ Aggressive or violent behavior
- □ Anger issues
- □ Argues with adults
- □ Bladder or bowel control problems
- □ Complaints about school behavior
- □ Criminal behavior/Involved with juvenile probation
- □ Cruelty/harm to animals
- □ Depression, Sadness or feeling down
- □ Developmental Delays (delays in learning, growth, speech, social)
- □ Drug Use/Alcohol Use/Tobacco Use
- □ Easily Distracted
- □ Eating problems (Not eating enough/Overeating)
- □ Fatigue/feeling tired/lack of energy
- □ Fear of "going crazy"
- □ Fear of losing control
- □ Feeling detached from body
- □ Flashbacks
- □ Hopelessness
- □ Housebound (Does not want to leave the house)
- □ Hyperactivity (Full of energy all day long)
- □ Identity issues (Confusion about who your child wants to be)
- □ Inappropriate sexual behavior
- □ Impulsive behavior (Does not think before acting)
- □ Irritability (Often acts miserable and complains a lot)
- □ Loss of a loved one, Loss of a relationship
- □ Lying
- □ Mood swings
- □ Nervousness (Worrying)
- □ Nightmares
- □ Numerous physical complaints (Complains about feeling sick)
- □ Obsessive thoughts (Cannot stop thinking about something no matter how much they try not to.)
- □ Panic Attacks
- □ Paranoia (Extreme fear or distrust of others)
- □ Poor grades
- □ Poor hygiene
- □ Poor relationships with other children/peers
- □ Problems concentrating
- □ Problems remembering things
- □ Recent trauma (please specify): _____
- □ Refusing to go to school
- □ Relationship or family conflict
- □ Running away from home
- □ Seeing or hearing things that other people cannot see/hear
- □ Self-harm such as cutting/burning self
- □ Setting fires
- □ Other_____

Client/Child's Name_____

SECTION 3: PSYCHIATRIC/MENTAL HEALTH ASSESSMENT

1. Is your child currently receiving mental health treatment with this agency or through another agency? If yes, explain what other services they are currently receiving.
   _____
   _____

2. Has your child ever had counseling services before? If yes, please list where and when.
   _____
   _____

3. Has your child ever been hospitalized for mental health problems before? If yes, please list where and when.
   _____
   _____

4. Has your child ever been diagnosed with a mental health condition? If yes, please list the diagnosis/diagnoses and who made the diagnosis/diagnoses. _____
   _____

5. Has your child ever spent time in a residential treatment facility or another long term treatment facility? If yes, please list where and the dates that they were in treatment.
   _____
   _____
   _____

6. Has your child ever stated that they wanted to kill themselves? If yes, are these statements something that they have talked about recently? If yes to any of the above, please explain:
   _____
   _____
   _____

7. Has your child ever stated that they wanted to harm or threaten someone else? If yes, please explain:
   _____
   _____
   _____

8. Has your child ever cut, burned or injured themselves in a way that was not an accident? If yes, please explain and note if is this a current concern:
   _____
   _____
   _____

SECTION 4: BRIEF FAMILY HISTORY

1. Does your child have any family members who suffer from mental health problems? If yes, please explain:
   _____
   _____
   _____

2. Does your child have any family members who suffer from drug and/or alcohol problems? If yes, please explain:
   _____
   _____
   _____

3. Does your child have any family members who have committed suicide? If yes, please explain:
   _____
   _____
   _____

4. Are there any concerns regarding family members (either living or deceased) that may be impacting your child at the present time? If yes, please explain.
   _____
   _____
   _____

SECTION 5: MEDICAL SCREENING: PERSONAL AND FAMILY MEDICAL HISTORY

1. Does your child have any current medical conditions? If yes, please list all current medical conditions.
   _____
   _____
   _____

2. Does your child complain about feeling sick and if so, what do they often complain that they feel sick from? Have they seen a doctor for any of these complaints?
   _____
   _____
   _____

3. Are there any family members close to your child that are suffering from any medical conditions that may be upsetting your child? If yes, please provide more information.
   _____
   _____

4. On average, how many hours of sleep does your child get per night?
   _____

5. To the best of your knowledge, what is your child's current weight and height? Do you or your doctor have any concerns about your child's weight?
   _____
   _____

6. Overall, do you think that your child has healthy eating habits? If no, please explain.
   _____
   _____

7. Does your child have a family doctor/primary care physician? If yes, please list doctor's name, agency they are affiliated with, and doctor's address and phone number if known.
   _____
   _____
   _____

8. Does your child take any medication(s)?If yes, please list their current medication name(s), dosage, how often they take the medication, who is prescribing the medication, and what they are taking the medication for.
   _____
   _____
   _____
   _____

9. Does your child have any allergies that you know of? If yes, please list.
_____
_____

10. Has your child ever had surgery or been hospitalized for any medical problems? If yes, please explain.
_____
_____
_____
_____

SECTION 6: EDUCATION

1. Is your child in school? If yes, what grade and what is the name of their school?
_____

2. Does your child have any behavior problems at school? If yes, please explain.
_____
_____
_____

3. If your child attends school, do they have an IEP (Individualized Educational Plan)? If yes, please explain.
_____
_____

4. If your child attends school, do they receive any extra support in school for learning or behavior problems? If yes, please explain what services they receive.
_____
_____
_____

5. Does your child have attendance problems with school? If yes, please explain.
_____
_____
_____

6. Does your child have problems with their teacher(s) in school? If yes, please explain.
_____
_____
_____

7. Please use the following space to list any other areas of concern that you may have concerning your child and his/her education.
_____
_____
_____

SECTION 7: SOCIAL RELATIONSHIPS

1. How well does your child get along with other children (classmates, siblings)?
_____
_____
_____

2. How well does your child get along with adults?
_____
_____

3. Is your child able to make friends easily? Please explain.
_____
_____
_____

4. Does your child bully others? If yes, please explain.
_____
_____
_____

5. Do other children/peers bully your child? If yes, please explain.
_____
_____
_____

SECTION 8: DEVELOPMENT

1. Was your child born healthy and without any complications? If no, please explain.
_____
_____
_____

2. Did your child walk, talk, toilet train, etc. at the correct developmental times? If no, please explain.
_____
_____

3. Did/Does your child receive speech therapy, occupational therapy, physical therapy, etc? If yes, please explain.
_____
_____
_____

4. Did your child have any exposure to drugs, alcohol or tobacco use by their mother during her pregnancy?
_____
_____

5. Was there any domestic violence between mother and any other parties when child's mother was pregnant with child? If yes, please explain.
_____
_____
_____

SECTION 9: LIVING SITUATION

1. Who does your child live with currently? Please list ALL household members, their relationship to child, and how well they get along.
_____
_____
_____
_____

2. Has your child had multiple changes in living situations throughout his/her life? If yes, please explain.
_____
_____
_____

3. Is there anyone living in the child's household who is suffering from a mental illness? If yes, please explain.
_____
_____

4. Is there anyone living in the child's household who has a drug/alcohol problem? If yes, please explain.
_____
_____

5. If the child does not live with biological family members, does the child have any contact with any of their birth parents, biological brothers/sisters, grandparents, etc.? If yes, please explain.
_____
_____
_____

SECTION 10: TRAUMA HISTORY

1. Has your child ever been physically, sexually, or emotionally abused? If yes, please explain.
_____
_____
_____

2. Has your child ever witnessed any type of traumatic events in their life? For example, been involved in a natural disaster, witnessed domestic violence, watched someone they care about die, witnessed drug and alcohol use in the home, etc. If yes, please explain.
_____
_____
_____
_____

3. If the child has been abused, was this abuse reported to Childline, Children and Youth Agency, and/or the police? Please explain what actions were taken if any.
_____
_____
_____
_____

SECTION 11: ADDICTION HISTORY:

1. Has your child ever drunk alcohol? If yes, what did they drink and how much did they drink?
_____
_____

2. How frequently is your child drinking alcohol?
_____
_____

3. How old was your child when they first started drinking alcohol?
   _____
   _____

4. Has your child ever used drugs? If yes, what specific drugs? How much did they use?
   _____
   _____

5. When was the last date your child used drugs? What did they use and how much did they use?
   _____
   _____

6. How frequently is your child using drugs?
   _____
   _____

7. How old was your child when they first started using drugs?
   _____
   _____

8. Has your child ever viewed pornographic materials? If yes, how frequently?
   _____
   _____

9. Does your child often continue to eat after they feel full? If yes, please explain.
   _____
   _____

10. Does your child ever feel guilty after eating? If yes, please explain.
    _____
    _____

11. Does your child ever deprive themselves of food? If yes, please explain.
    _____
    _____

12. Does your child spend excessive time with media devices such as phone/computer/gaming? If yes, please explain.
    _____
    _____

13. Is there any other behavior that you believe your child does in excess or are concerned about? If yes, please explain.
    _____
    _____

ADDICTION TREATMENT:

1. Have you ever been concerned at any time about any of the above behaviors listed in questions 1-13? If yes, please explain.
   _____
   _____

2. Is anyone concerned about your child regarding the above behaviors listed in questions 1-13? If yes, please explain.
_____
_____

3. Have any of the above behaviors listed in questions 1-13 impacted your child's relationships with family and friends? If yes, please explain:
_____
_____

4. Have any of the above behaviors listed in questions 1-13 impacted your child's ability to perform their responsibilities at home, school and/or at work (if applicable)? If yes, please explain.
_____
_____

5. Has your child ever received treatment for any of the above behaviors listed in questions 1-13? If yes, where and when?
_____
_____

6. Would you like your child to receive help for any of the above behaviors listed in questions 1-13?
_____
_____

SECTION 12: CHILD'S STRENGTHS

1. What does your child enjoy doing for fun?
_____
_____
_____

2. Who/What does your child have in their life that provides them with support and hope?
_____
_____
_____

3. What do you think that your child can do that makes them stand out in a positive way?
_____
_____
_____

4. Is your child involved in any activities in school or in the community, for example: work, sports, clubs, group activities or organizations? Please list these activities.
_____
_____
_____

5. Does your child have anyone in the community who works with them to provide them and the family with extra support, for example: Caseworkers, Big Brother/Big Sister, etc.? If yes, please explain.
_____
_____
_____

Client/Child's Name_____

SECTION 13: OTHER

Please use the following space to list anything concerning the client/child that may not have been asked that you would like to be addressed.

_____
_____
_____
_____
_____
_____

I verify all information is truthful to the best of my knowledge (please sign below):

_____
Parent/Guardian Signature Date

STAFF USE ONLY

I verify I reviewed the above information:

_____
Staff Signature Date
Printed Name of Clinician Reviewing this form_____

_____
Staff Signature Date
Printed Name of Clinician Reviewing this form_____