CHILDREN / ADOLESCENTS (Age 17 and under)
SOCIAL / MEDICAL HISTORY
BIOPSYCHOSOCIAL ASSESSMENT

Please answer all questions, do not write in boxes labeled psychologist use only. Thank you.

Child's Name: ____ Date: ___________________

Child's age: ________ Date of Birth: ____ / ____ / ______ Sex (circle one): Male Female

Address: ____

Street _____________________________________ ________________ __________________

City State Zip ____

Phone: (Home) _______________________________ (Cell) _______________________________

Person filling out form: ____

Name of person responsible for bill: ____

Emergency Contact: ____________________ Relationship _______________ Phone _____________

Parents / Stepparents Mother's name: ________________________ Age: _____ Education: _________

Occupation: ______________________

Father's name: _______________________ Age: _____ Education: _________

Occupation: _____________________

Stepparent's name: ___________________ Age: ______ Education: ________

Occupation: _____________________

Stepparent's name: ___________________ Age: ______ Education: ________

Occupation: _____________________

Marital status of parents: ___________________

If parents are separated/divorced, how old was child at time of separation? __________________

With whom does the child live? ____

Custody: □ Lives in one home with both legal parents. □ Mother has physical custody.

□ Father has physical custody. □ Physical custody is shared. □ Other: ___________________________

List all people living in household:

Name	Age	Relationship to child

If any brothers or sisters are living outside the home, list their names and ages:
____
____

If any brothers / sisters are deceased, please give name and year: ______________________________

FAMILY INFORMATION:

Place of birth: ___________________________

Child's Race: □ African-American □ Caucasian □ Native American □ Hispanic □ Asian □ Latino □ Other (specify) ____________________________________

Was the child adopted? □ Yes □ No If yes, at what age? _______ From where? __________________

Has the child ever been placed outside of the home? □ Yes □ No If yes, where? __________________

In how many residences has the child lived since birth? ____

Has the child been physically or sexually abused, assaulted or molested? □ Yes □ No □ Don't know

If yes, specify by whom and when: ____

Have the child's parents or any other family members had any mental health or emotional problems?

□ Yes □ No If yes, describe: ____

PRESENTING PROBLEM:

Briefly describe your child's current difficulties: ____
____
____

How long has this problem been of concern to you? ____

When was the problem first noticed? ____

What seems to help the problem? ____

What seems to make the problem worse? ____

Has the child received evaluation or treatment for the current problem or similar problems?

□ Yes □ No If yes, when and with whom? ____

Is the child on any medication at this time? □ Yes □ No

If yes, please note kind of medication: ____

How do you want your child's situation to be different after coming here? ______________________________
____
____
____
____

For Psychologist Use Only:

Presenting Problem / History of Problem:

Symptoms:

Interview / Observation of child:

SOCIAL AND BEHAVIOR CHECKLIST:

Place a check next to any behavior or problem that your child currently exhibits.

□ Has difficulty with speech
□ Has difficulty with hearing
□ Has difficulty with language
□ Has difficulty with vision
□ Has difficulty with coordination
□ Prefers to be alone
□ Does not get along well with other children
□ Is aggressive
□ Is shy or timid
□ Has poor bowel control (soils self)
□ Is more interested in things (objects) than in people
□ Has frequent tantrums
□ Has frequent nightmares
□ Has trouble sleeping (describe) ______________
□ Has blank staring spells
□ Has difficulty with coordination
□ Rocks back and forth
□ Bangs head
□ Holds breath
□ Eats poorly
□ Is stubborn
□ Is much too active
□ Engages in behavior that could be dangerous to self (describe) ____

Describe child's relationship with his / her:

Father ____

Mother ____

Sibling(s)____

Step parent(s) ____

OTHER INTERPERSONAL RELATIONSHIPS:

How do you describe the child's friendships:

□ No Friends □ Only Acquaintances □ Both acquaintances and close friends

How many close friends? ___________

Place a check next to any behavior or problem that your child currently exhibits.

☐ Has special fears, habits, or mannerisms
☐ Show daredevil behavior
☐ Gives up easily
☐ Wets bed
☐ Is impulsive (describe) ______________________
____
☐ Sucks thumb
☐ Is slow to learn
☐ Other (describe): ____
____

EDUCATIONAL HISTORY:

School: ____ Grade: __________________

Place a check next to any educational problem that your child currently exhibits:

Check
☐ Has difficulty with reading
☐ Has difficulty with arithmetic
☐ Has difficulty with spelling
☐ Has difficulty with writing

Check
☐ Has difficulty with other subjects (please list)
____
____
☐ Does not like school

Is your child in a special education class? ☐ Yes ☐ No

If yes, what type of class? ____

Has your child been held back in a grade? ☐ Yes ☐ No

If yes, what grade and why? ____

Has your child ever received special tutoring or therapy in school? ☐ Yes ☐ No

If yes, please describe: ____

Has your child ever been suspended or expelled? ☐ Yes ☐ No

If yes, please describe: ____

DEVELOPMENTAL HISTORY:

During pregnancy, was mother on medication? ☐ Yes ☐ No If yes, what kind? ______________

During pregnancy, did mother smoke? ☐ Yes ☐ No If yes, how many cigarettes each day? ____

During pregnancy, did mother drink alcoholic beverages? ☐ Yes ☐ No

If yes, what did she drink? ____

Approximately how much alcohol was consumed each day? _____________________________________

During pregnancy, did mother use drugs? ☐ Yes ☐ No If yes, what kind? __________________

Were forceps used during delivery? ☐ Yes ☐ No

Was a Cesarean section performed? ☐ Yes ☐ No If yes, for what reason? ____________

Was the child premature? ☐ Yes ☐ No If so, by how many months? _______________________

What was the child's birth weight? ____

Were there any birth defects or complications ☐ Yes ☐ No
If yes, please describe: ____

Were there any feeding problems? ☐ Yes ☐ No If yes, please describe: _________________________
____

Were there any sleeping problems? ☐ Yes ☐ No If yes, please describe: _________________________
____

As an infant, was the child quiet? ☐ Yes ☐ No
As an infant, did the child like to be held? ☐ Yes ☐ No
Were there any special problems in the growth and development of the child during the first few years?
☐ Yes ☐ No If yes, please describe: ____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

	Age		Age
Showed response to parent	______	Put several words together	______
Rolled over	______	Dressed self	______
Sat alone	______	Became toilet trained	______
Crawled	______	Stayed dry at night	______
Walked alone	______	Fed self	______
Babbled	______	Rode tricycle	______
Spoke first word	______		

CURRENT HEALTH INFORMATION:

Describe child's health generally: ☐ Good ☐ Fair ☐ Poor
Is the child sexually active? ☐ Yes ☐ No
List any health problems the child has had: ____
____
____

Does the child have:

Current immunizations ☐ Yes ☐ No Which are needed? ______________________________________
Any allergies ☐ Yes ☐ No Specify ____
Nutritional problems ☐ Yes ☐ No Specify ____
Appetite problems ☐ Yes ☐ No Specify ____
Sleep problems ☐ Yes ☐ No Specify ____
A disability or handicap ☐ Yes ☐ No Specify ____
Contagious or other diseases ☐ Yes ☐ No Specify ____
Any accidents / injuries ☐ Yes ☐ No Specify ____
Dental, vision or hearing problems ☐ Yes ☐ No Specify ____________________________________
Any hospitalizations ☐ Yes ☐ No Specify ____
Physician: ____

Name City Date of last contact: ____ / ____ / ____ Reason for last contact: __________________________

SUBSTANCE USE / ABUSE:

Please complete the chart below.

Category of Drug	Has child ever used?	Currently using?	Age at first use	How often does child use?	How taken?	How much?	Use last 48 hours?	Withdrawal symptoms
Alcohol	□ Yes □ No	□ Yes □ No						
Stimulant	□ Yes □ No	□ Yes □ No						
Cocaine	□ Yes □ No	□ Yes □ No						
Tranquilizer	□ Yes □ No	□ Yes □ No						
Barbiturate	□ Yes □ No	□ Yes □ No						
Marijuana	□ Yes □ No	□ Yes □ No						
Opioid	□ Yes □ No	□ Yes □ No						
Hallucinogen	□ Yes □ No	□ Yes □ No						
Prescribed	□ Yes □ No	□ Yes □ No						
Nicotine	□ Yes □ No	□ Yes □ No						
Caffeine	□ Yes □ No	□ Yes □ No						
Other	□ Yes □ No	□ Yes □ No						

FAMILY MEDICAL HISTORY:

Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child.

□ Alcoholism _______________________________

□ Cancer ___________________________________

□ Diabetes _________________________________

□ Heart trouble _____________________________

□ Bipolar Disorder ___________________________

□ Anxiety Disorder ___________________________

□ Depression _________________________________

□ Learning disability ___________________________

□ ADHD _____________________________________

□ Mental Retardation __________________________

□ Other _____________________________________

RELIGION / SPIRITUALITY:

Religion: □ Protestant □ Catholic □ Buddhist □ Hindu □ Jewish □ Muslim □ Atheist □ Agnostic

□ Other: _______________________________

LEGAL INFORMATION:

Has the child ever:

Had difficulty or contact with police? □ Yes □ No
Appeared in juvenile conference? □ Yes □ No
Been on probation? □ Yes □ No

Please explain: ____

____

OTHER INFORMATION:

What are your child's favorite activities?

1. ____ 2. ____

3. ____ 4. ____

5. ____ 6. ____

What activities would your child like to engage in more often than he/she does at present?

1. ____ 2. ____

What activities does your child like least?

1. ____ 2. ____

What disciplinary techniques do you usually use when your child behaves inappropriately?

Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

□ Ignore problem behavior
□ Scold child
□ Spank child
□ Threaten child
□ Reason with child
□ Redirect child's interest
□ Don't use any technique
□ Tell child to sit on chair
□ Send child to his or her room
□ Send child to his or her room
□ Take away some activity or food
□ Other technique (describe) __________________

Which disciplinary techniques are usually effective? ____

____

With what type of problem(s)? ____

____

Which disciplinary techniques are usually ineffective? ____

____

With what type of problem(s)? ____

____

What have you found to be the most satisfactory ways of helping your child? _________________________

____

What are your child's assets or strengths? ____

____

PREVIOUS COUNSELING / PSYCHOTHERAPY:

Has your child ever been in counseling / therapy before? □ Yes □ No

Name of Provider Clinic Year Diagnosis / Problem

____

____

____

Has your child been prescribed psychotropic medication? □ Yes □ No

Medication: ___________________________ Dosage: ___________ Prescribed by: _______________________

Medication: ___________________________ Dosage: ___________ Prescribed by: _______________________

Medication: ___________________________ Dosage: ___________ Prescribed by: _______________________

Reason: ____

Other medications currently prescribed:

Medication: ___________________________ Dosage: ___________ Prescribed by: _______________________

Medication: ___________________________ Dosage: ___________ Prescribed by: _______________________

Medication: ___________________________ Dosage: ___________ Prescribed by: _______________________

Reason: ____

Check if applicable:

□ Inpatient □ Day Treatment □ Substance Abuse Program □ Psychological Testing
□ Partial Hospitalization

Explain any of the above: ____

____

Has the child ever: Made a suicide attempt: □ Yes □ No

If yes, when? ____

Expressed homicidal thoughts: □ Yes □ No

Describe ____

Had episodes of explosive anger: □ Yes □ No

Describe ____

Is the child currently expressing homicidal / suicidal feelings? □ Yes □ No

* * * * * * * * * * * * * * * * * * * *

Signature of Informant ____Date _______________________

Relationship to client ____

Signature of Psychologist ____ Date _______________________

For Psychologist Use Only:

SUICIDALITY / HOMICIDALITY:

□ Client denies any current suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

□ Client reports current suicidal or homicidal feelings. Specify: ____________________________________
____

□ Client denies history of suicidal or homicidal thoughts, feelings, gestures, intentions, or plans.

□ Client has history of suicidal or homicidal thoughts, feelings, gestures, intentions or plans. Specify:
____
____

MENTAL STATUS:

General Behavior: cooperative, passive, withdrawn, dramatic, restless, hostile, anxious, other __________
Attire: appropriate, seductive, untidy, loud, meticulous, other _____________________________________
Gait: normal, erect, stooped, ataxic, rigid, shuffling, manneristic, other ______________________________
Motor Activity: normal, agitated, retarded, tremor, tic, mannerism, other ____________________________
Stream of Thought: Productivity: spontaneous, verbose, pressured speech, unproductive,
other ____
Progression: normal, loose, circumstantial, preservation, halting, blocking, incoherent, fragmented,
other ____
Language: normal, baby-talk, peculiar, expression, stilted, other ___________________________________
Emotional Tone & Reactions: Mood: normal, indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, composed, anxious, sad, tearful, depressed, other ____
Affect: appropriate, inappropriate, other ____
Mental Trend / Content of Thoughts: Perception: normal, auditory hallucination, visual hallucination, illusions, depersonalization, hypochondriasis, other ____
Orientation: normal, disoriented to time, place, person, other _____________________________________
Memory: normal, defective (remote, recent, immediate), other ______________________________________
General Knowledge: consistent with education, inconsistent, able to abstract, concrete, other __________
Insight: absent, good, fair, minimal Judgment: good, fair, poor

DIAGNOSTIC SUMMARY:

For Psychologist Use Only:

Diagnostic Impressions:

Axis I ____

Axis II ____

Axis III ____

Axis IV ____

Axis V (GAF) _________________

For Psychologist Use Only:

Goals for treatment:

1. ____
2. ____
3. ____
4. ____
5. ____

____ _____________________________

Psychologist Signature Date