CHILD/ADOLESCENT (Under Age 18)
BIOPSYCHOSOCIAL ASSESSMENT

Please answer all questions. Please do not write in boxes labeled *therapist use only*. Thank you!

Child/Teen's Name	Preferred Name	Birthdate
Person completing this form		Today's Date

Your treatment goals are of highest importance to us. Please complete the following questions; your therapist will discuss these with you at your first visit.

Why are you coming to treatment now?

What would you like to be different after treatment here?

Strengths & Abilities Child's/teen's assets, natural positives (examples: good support system, motivated, coping skills, etc) and child's/teen's skills, capabilities, competencies and talents (e.g., capacity to learn, common sense, academic intelligence, social skills, creativity, etc)

Needs Specific things that will make treatment here successful (e.g., figuring out consistent transportation, prioritizing therapy, accessibility of services re: disability, need for assistive technology, support of family, etc)

Preferences Things that will *enhance* child's/teen's treatment experience (e.g., trying therapy with or without psychiatric medications, type of therapy, type of therapist, appointment times/days, etc).

Strengths and Treatment Preferences of Parent(s)/Guardian(s)

Barriers What might get in the way of achieving the goals that bring the child/teen here?

What has already been done or tried to do to address the goals that bring the child/teen here?

PSYCHOLOGICAL SYMPTOMS AND HISTORY

Please check any of the following that currently apply to the child/teen

- □ Worrying too much
- □ Feeling tense
- □ Feeling fearful
- □ Panic attacks
- □ Startle easily
- □ Trauma/abuse
- □ Being scared for no reason
- □ Worrying what others think about him/her
- □ Having to redo things or check things
- □ Doing things very slowly to make sure they are correct
- □ Unwanted thoughts
- □ Avoids situations/people/ things due to fear
- □ Asking others for reassurance
- □ Family problems
- □ Problems with parents/guardians
- □ Difficulty making friends
- □ Withdrawing
- □ Loneliness
- □ School problems
- □ Trouble concentrating
- □ Easily distracted
- □ Memory problems
- □ Racing thoughts
- □ Procrastination
- □ Careless mistakes
- □ Starts but doesn't finish tasks
- □ Irritability/easily annoyed
- □ Sadness
- □ Crying easily
- □ Hopelessness
- □ Worthlessness
- □ Low self-confidence
- □ Feeling inferior
- □ Low energy level
- □ Difficulty making decisions
- □ Feeling confused
- □ Loss of interest/pleasure
- □ Thoughts of suicide
- □ Increased sleep
- □ Decreased sleep
- □ Problems falling asleep
- □ Problems staying asleep
- □ Fatigue/feeling tired
- □ Nightmares
- □ Appetite change
- □ Self injury/cutting
- □ Excessive spending
- □ Impulsivity
- □ Hyperactivity
- □ Seeing/hearing things that other people don't see/hear
- □ Feeling something is wrong with their mind
- □ Feeling disoriented or confused
- □ Feeling high without being on drugs
- □ Mood swings
- □ Feeling numb
- □ Feelings being easily hurt
- □ Intrusive thoughts
- □ Difficulty controlling Actions
- □ Being suspicious of others
- □ Death/grief/loss
- □ Weight
- □ Purging
- □ Food restriction
- □ Hair-pulling
- □ Skin-picking
- □ Upset Stomach
- □ Headaches
- □ Anger
- □ Defiance
- □ Bedwetting
- □ Toileting issues
- □ Sexualized behaviors
- □ Excessive tantrumming
- □ Indiscriminate sociability
- □ Unable to use caregivers for support/help
- □ Repetitive/traumatic play
- □ Other:

Please note: *Substance use concerns are explored in detail at the end of this packet*

PREVIOUS COUSELING/PSYCHOTHERAPY

Has the child/teen been seen previously for treatment or evaluation of emotional or behavioral concerns? □ Yes □ No

Check if applicable: □ Inpatient □ Residential □ Day Treatment/Partial Hospitalization □ Substance Abuse Program
□ Outpatient □ Psychological Testing □ Psychiatric Evaluation □ ______________________________

Name of Facility and/or Provider	Date(s)	Problem Area/Diagnosis & Type of Therapy	Was it helpful?

Has the child/teen had (now or in the past): □suicidal feelings or thoughts □suicide plan □suicide attempt(s)
□self-harm behavior (cutting, etc) □explosive anger □homicidal feelings, thoughts or plan □______________________
□no history of suicidal/homicidal thoughts, plans or actions, now or in the past **Comments**

Abuse/Trauma Has the child/teen been (now or in the past) the □victim of, □witness to, or □perpetrator of:
□ physical abuse or assault □ a life-threatening event □ sexually abuse or assault □ emotional or verbal abuse □ neglect
□ bullying □ no history of abuse/trauma/neglect **Comments**

Does the child/teen currently have concerns about their personal safety? □Yes □No If Yes, please describe

Client Name ______________________________________

HEALTH INFORMATION

Physician:
Date of Last Well Child/Annual Exam:
How is child/teen's health in general? □ Excellent □ Good □ Fair □ Poor □ Other:___________

Current on immunizations? □ Y □ N
Sexually Active? □ Y □ N
Is the teen pregnant? □ N/A □ Y □ N If yes, # weeks:___________

PREGNANCY, DELIVERY AND INFANCY INFORMATION

Did biological mother use any of the following substances during pregnancy? (□ check this box if information is not available)
□Alcohol □Drugs □Coffee/Caffeine □Tranquilizers/sleeping pills □Anti-seizure medications □Insulin or other diabetes treatment □Other prescribed or nonprescribed medications □Other substances □none of these
If substances were checked above, please describe amount used and frequency (how often)

Did biological mother experience any health problems or illness during pregnancy? □ Y □ N
Were there any pregnancy or delivery complications? □ Y □ N
Were specialized medical attention or tests required at birth? □ Y □ N
Comments

EARLY CHILDHOOD (PRE-KINDERGARTEN) DEVELOPMENT

One or more major developmental milestones were not met (sitting up, first words, phrases, etc) □ Y □ N
Did pediatrician, other professionals, or parent(s)/guardian(s) have any concerns about child's early development? □ Y □ N
If yes to either of above, please describe

Check any of the following that the child/teen has had or currently has

□ Major accident/injury
□ Hospitalization
□ Surgery
□ Adverse medication reaction
□ Allergies
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Birth defects
□ Bladder problems
□ Blood pressure (high/low)
□ GI problems
□ Cancer
□ Cerebral Palsy
□ Chronic fatigue
□ Dental problems
□ Diabetes
□ Epilepsy
□ Fibromyalgia
□ Head trauma (loss of consciousness? □Y □N)
□ Headaches
□ Hearing problem
□ Heart disease
□ Hepatitis A B or C
□ Hypoglycemia
□ Huntington's
□ Kidney problems
□ Learning Disability
□ Liver problems
□ Lung condition
□ Menopause
□ Multiple Sclerosis
□ Parkinson's Disease
□ Speech/language problem
□ Stroke
□ Thyroid (Hypo/Hyper)
□ Ulcer
□ Vision problem
□ Other (please list):

Please provide additional detail about items checked above:

Does the child/teen have any disabilities not noted thus far? □ Y □ N ***If Yes, please describe:***

Does child/teen use any assistive devices/technology? □ Y □ N ***If Yes, please describe***

Client Name ___________________________________

Please list all current prescribed &/or over-the-counter medications/supplements. (If none, check this box ☐)

Medication	Dosage	Prescribed by	Medication	Dosage	Prescribed by

If psychiatric medications are listed above, do they seem to be helping? ☐ No ☐ A little ☐ Moderately ☐ A lot

Please list any psychiatric medications the child/teen has used in the past:

FAMILY INFORMATION

Child/teen's place of birth:

Was child/teen adopted? ☐ Yes ☐ No

If yes, age at adoption__________

Caregiving situation prior to adoption:

☐Foster family ☐orphanage ☐other____________

Number of foster placements________

Ethnic identification ☐ African American ☐ Caucasian ☐ Native American ☐ Hispanic ☐ Latino ☐ Asian ☐ Other (please specify):

Sexual Identification ☐Straight ☐Gay/Lesbian ☐Bisexual ☐Not Listed

Gender Identity & Expression ____________________________

Parents are ☐ Married/Partnered/Cohabitating ☐ Separated ☐ Divorced ☐ Other______________________________

If parents are not living together, please describe visitation or coparenting schedule

Please list people currently living with the child/teen in their primary residence

Name	Relationship to child/teen	Age	Occupation/ School Grade	Satisfied with relationship? (Y/N)	Comments

Please list Family Members not living with the child/teen in their primary residence

Name	Relationship to child/teen	Age	Occupation/ School Grade	Satisfied with relationship? (Y/N)	Comments

Client Name ______________________________

Family Mental Health Does the child/teen have any immediate family members who have had mental health problems (anxiety, depression, substance use, suicide, etc)? □ Yes □ No If yes, please describe

Friendships □ No friends □ Only acquaintances □ Acquaintances & friends How many close friends?________________
Is teen dating? □Yes □ No
Comments

Describe child's/teen's relationship with their family members (parents, siblings, step parents, etc)

Does child/teen have sufficient social support? □ Yes □ No Comments:

EDUCATIONAL INFORMATION

Schools attended

School Name	Grades attended (preschool – 12)	Favorite Subjects	Least Favorite Subjects	Average Grades	Comments

What are the child/teen's average grades in the past 6 months?

Is child/teen performing to potential at school? □Yes □No □N/A Does the child/teen currently enjoy school? □Yes □No □N/A
Has the child/teen had current or past □ IEP □ Tutoring □ School suspension □ School expulsion □ None of these
Literacy Level: □ Not able to read □ Recognize 1 or 2 words when reading □ Read some/most simple writing □ Advanced reader
Comments for above items

Employment History (if N/A, check this box □)

Job	Organization	Length of Time	Satisfied with Job?	Reason for Leaving

Comments:

RELIGION/SPIRITUALITY
□Protestant □Catholic □Jewish □Buddhist □Hindu □Muslim □Agnostic □Atheist □Other
Presently active in religion/spirituality? □Yes □No □N/A Satisfied with religion/spirituality? □Yes □No □N/A
Comments:

SUBSTANCE USE: Please complete the chart below and circle any of the substances listed if teen has used them in the past 48 hours.

Category of Substance	Current Use?	Ever used?	*Please complete these questions for substances teen currently uses*						
			Amount and Frequency of Use (e.g., 8 beers/day)	Maximum amount used	Use has led to problems (social, health, legal, work)	Don't do what's expected of him/her due to use	Others express concern about teen's use	Have urges to use, or tried to cut down or stop	With-drawal symptoms
Alcohol	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Stimulant	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Cocaine	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Tranquilizer	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Barbiturate	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Marijuana	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Opioid	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Hallucinogen	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Prescribed	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Nicotine	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Caffeine	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y
Other	□N □ Y	□N □ Y			□N □ Y	□N □ Y	□N □ Y	□N □ Y	□N □ Y

Does teen travel with driver(s) under the influence? □Yes □No   Does teen drive after substance use? □Yes □No

Does teen see negative consequences to substance use? □Yes □No

What does the teen like about substance use?

LEGAL INFORMATION

Child/teen (currently and/or or in past):   If any legal difficulties, please describe:

□Had difficulty or contact with police?

□Appeared in juvenile conference?

□Been convicted of a crime?

□Been on Probation?

□No history of legal problems

LEISURE ACTIVITIES

Please list child/teen's non-school activities and preferences for spending non-school time:

Comments (e.g., enjoyment, satisfaction, etc)

Client Name ______________________________

***************THIS IS THE END OF THE CLIENT PORTION OF THIS FORM**********

For Therapist Use Only

OBSERVATION OF CLIENT

SUBSTANCE USE

☐ Personal history of use ☐ Family history of abuse/dependence

Possible Markers ☐Anxiety ☐Depression ☐Moody, angry, irritable ☐Isolating self ☐Sleep problems ☐Parents do not like friends ☐Conflict with family ☐Focus/concentration problems

Substance Abuse ☐ Role impairment ☐Hazardous use ☐Legal problems ☐Social/Interpersonal problems

Substance Dependence (3+, 12 mo) ☐ Tolerance ☐ Withdrawal symptoms ☐ Larger amounts/longer period than intended ☐ Social/work/recreational activities reduced ☐Use despite physical/psychological consequences ☐Excessive time obtaining/using/recovering ☐Desire to cut down/Unsuccessful control attempts
☐ Physiological dependence ☐ Remission (early full, early partial, sustained full, sustained partial)

☐ No meaningful SA concerns ☐ Consult with Site Manager ☐ Further screening needed ☐Formal evaluation indicated ☐Referral Indicated

Comments *(if consult/eval needed, document date completed and consultant's name below and detail relevant information in a progress note)*

MEDICAL AND DEVELOPMENTAL HISTORY

Motor development/functioning: *within normal limits?* ☐*Y* ☐ *N, describe*

Speech, hearing, language, communication skills *within normal limits?* ☐*Y* ☐ *N, describe*

Visual functioning *within normal limits?* ☐*Y* ☐ *N, describe*

Congenital problems *within normal limits?* ☐*Y* ☐ *N, describe*

ADDITIONAL MEDICAL HISTORY (Include adjustment to disabilities and/or medical conditions or ☐ N/A *as well as* relationship of physical health to current mental health or ☐ N/A)

PHYSICAL ACTIVITY & NUTRITION ☐no concerns ☐limited physical activity ☐calorie restriction ☐diet ☐food group avoidance ☐emotional overeating ☐binge eating ☐purging ☐ruminative thoughts about food/weight ☐body image concerns ☐history of food concerns ☐____________________

Assessment ☐Incorporate physical activity into treatment ☐Eating inventory assigned ☐Consult w/ Site Manager ☐Referral to specialist needed ☐No problem indicated

LEGAL STATUS (☐ no legal concerns or history)

☐ **Client/parent/guardian given information about legal assistance if relevant**

Client Name ______________________________

FAMILY/SOCIAL HISTORY AND FUNCTIONING *Please include brief history/functioning as well as discussion of potential impact & integration of applicable items into treatment*

Family history, present family situation, family system

Family expectations of client

Assessment of parent(s)/guardian(s) parenting skills

Strengths/resources in family/friends; need for social supports; assessment of social relationships

Spirituality/cultural background/family values/ethnicity/gender identity/sexual orientation/gender expression
(□ No concerns relate to ethnicity when asked)

Parent/Guardian treatment preferences and willingness/ability to participate in treatment

Assessment of Impairment □None □Mild □Mild to Moderate □Moderate □Moderate to Severe □Severe **Comments**

ACADEMIC/LEISURE FUNCTIONING

Daily activities pattern

School history and current school performance

Cognitive functioning including learning ability and intellectual functioning

Leisure activities/hobbies; Activities that may be beneficially integrated into treatment

Assessment of impairment □None □Mild □Mild to Moderate □Moderate □Moderate to Severe □Severe **Comments**

INITIAL RISK ASSESSMENT

Child/teen reports current □ Ideation □ Intent □Means □Plan □None of These **Comments** *including potential protective & risk factors*

Child/teen reports past □ Ideation □Intent □Means □Plan □ Attempts □None of These **Comments**

Child/teen reports other past or current risk-taking behaviors □ No □ Yes, comments:

Intervention Needed □ None □ Complete Full Risk Assessment □ Safety Plan □ No Harm Contract □ Consult with Site Manager □ Referral to Higher Level of Care

MENTAL STATUS

General Behavior □ Cooperative □Passive □Withdrawn □Dramatic □Restless □Hostile □Guarded

Appearance □Tidy □Unkempt □Disheveled □Other **Orientation X 4** □Adequate □Deficiency→ □Time □Place □Person □Situation

Motor Activity □Normal Limits □Agitated □Psychomotor Retardation □Tremor □Tic □Mannerism □Stereotypy □Difficulty sitting still □Lack of Eye Contact

Affect Intensity □Full range □Constricted Range □Flat □ Blunted □Exaggerated □ Dramatic □Other

Affect Mobility □ Unremarkable □Constricted □Fixed □Immobile □Labile □Reactive □Unreactive

Mood □Euthymic □Euphoric □Depressed □Tearful □Sad □ Anxious □Angry □Composed □Labile □Alexythymic

Speech □Normal Limits □Loud □Soft □Non-spontaneous □Slowed □ Hesitant □ Rapid □Pressured g □Excessive □Incoherent □Articulation Problems □Prolonged Latency □ Repetition of Words □ Other

Thought Process □Normal Limits □Flight of Ideas □Inhibited □Poverty of Thought □Perseveration □Disorganized □Ruminative □Circumstantial

Thought Content □Normal Limits □Illogical □Delusional □Overvalued Ideas □Paranoid □Obsessions □Preoccupations

Perception □Normal Limits □Hallucinations □Pseudohallucinations (e.g., hypochondriasis) □Illusions

Alertness □Unremarkable □Impaired **Memory** □Normal Limits □Inadequate→ □Immediate □Recent □Remote

Attention/Concentration □Normal Limits □Mild Impairment □Moderate Impairment □Severe Impairment

General Knowledge □ Unremarkable □ Inconsistent with Education □Overly Abstract □Concrete

Insight □Absent □Good □Fair □Minimal □None **Judgment** □Good □Fair □Poor

DIAGNOSTIC SUMMARY (including symptoms and functional impairment supporting DSM-IV diagnosis; include discussion if applicable of co-occurring disabilities, etc)

Client Name ______________________________

DIAGNOSTIC IMPRESSIONS (DSM-IV Code and Diagnosis)

Axis I : ____________________

Axis I : ____________________

Axis II : ____________________

Axis III : ____________________

Axis IV : ____________________

Axis V (GAF) ________

____________________ ____________________

Therapist's Signature Date

Client Name ____________________