For Internal Use Only
Counselor Initials/Date Reviewed:_____
Client Declined:_____
Client Did Not Return:_____

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Please write N/A for any questions that do not apply to your child

Today's Date: _____

Youth Name: _____ Age: _____ DOB: _____

Name of Person completing the form: _____ **Relationship to Client: _____**

PLEASE DESCRIBE ANY CULTURAL OR RELIGIOUS INFLUENCES IN YOUR FAMILY:

_____
_____
_____

PRESENTING PROBLEM CATERGORIZATION: (Please check all that apply and circle the description of symptom)

Symptoms causing concern, distress, or impairment:

- ☐ **Change in sleep patterns:** sleeping more sleeping less difficulty falling asleep difficulty staying asleep difficulty waking up difficulty staying awake
- ☐ **Concentration:** Decreased Concentration Increased Concentration
- ☐ **Change in appetite:** Increased appetite Decreased appetite
- ☐ **Increased anxiety (describe):** _____
- ☐ **Mood swings (describe):** _____
- ☐ **Behavioral problems/changes (describe):**
  _____
  _____
- ☐ **Other (please explain):** _____

RECENT SIGNIFICANT EVENTS:

☐Death of family member/friend ☐Change to Health ☐Change in Lifestyle ☐Loss/Change of Job
☐Change in Income ☐Change in Housing ☐Deployment of a Family Member ☐None

PREGNANCY & BIRTH HISTORY

Was your child adopted? ☐Yes ☐No If yes, at what age? _____
If yes, was it a(n): ☐Domestic Adoption ☐International Adoption (Country: _____)

Were there any complications during pregnancy? ☐Yes ☐No If yes, please explain: _____
_____

Was your child born prematurely? ☐Yes ☐No If yes, please explain: _____
_____

Were there any complications during birth? ☐Yes ☐No If yes, please explain: _____
_____

Were drugs or alcohol consumed during pregnancy? ☐Yes ☐No

Child's weight at birth: _____lbs. _____oz.

Child's health at birth: _____ **Length of hospital stay:** _____

Post-partum depression? ☐Yes ☐No

FOSTER CARE INVOLVEMENT:

Has your child ever been in foster care? ☐Yes ☐No ☐ Unknown
If yes, from what ages? _____ Reason: _____

Type of placement: ☐Familial Placement ☐ Non-Familial Placement

DEVELOPMENTAL HISTORY:

Do/did you have concerns about your child's development in any of the following areas below?
☐ Speech/Language ☐ Motor Skills ☐ Cognitive/Intellectual ☐Sensory ☐ Behavioral ☐ Emotional ☐ Social

Were there any significant disturbances/changes during your child's childhood? ☐Yes ☐No
If yes, please describe: _____
_____
_____

HEALTH HISTORY:

Does your child have any health issues? ☐Yes ☐No If yes, please describe: _____
_____

Is your child taking any medications? ☐Yes ☐No If yes, please list: _____
_____

Has your child ever had a serious accident/illness or hospitalization? ☐Yes ☐No If yes, please describe:
_____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Has your child ever been seen by a counselor or psychiatrist before? ☐Yes ☐No
If yes, please list provider's name: _____

Has your child ever been diagnosed with a mental health/emotional/psychological condition?
☐Yes ☐No If yes, what diagnosis was your child given? _____

SAFETY CONCERNS:

Is your child presently suicidal? ☐Yes ☐No If yes, please explain: _____
_____

Has your child ever attempted suicide? ☐Yes ☐No If yes, when and how? _____
_____

Is there a history of suicide in your child's immediate and/or extended family? ☐Yes ☐No

Is your child presently homicidal? ☐Yes ☐No If yes, please explain: _____
_____

CURRENT FUNCTIONING:

Do you have concerns about your child in the following areas? (check all that apply)
☐ Eating ☐ Hygiene/Grooming ☐ Sleeping ☐ Activities/Play ☐ Social relationships

If so, please describe: _____
_____

Approximately how many cups of water does your child drink each day? ☐ 2 ☐ 4 ☐ 8 ☐ 10

How often does your child eat during a typical day? ☐ Every 2 hours ☐ Every 3 hours ☐ Every 4 hours

EDUCATION:

How would you describe your child's achievement/grades in school? _____

How would you describe your child's attitude towards school/education? _____

What are peer relationships like at school? _____

Disciplinary or behavioral issues at school? ☐Yes ☐No If yes, please describe: _____
_____

Has your child been the victim of bullying? ☐Yes ☐No **If yes, please circle all that apply:**

Physical Bullying Verbal Bullying Cyber Bullying Relational Bullying Sextortion

Please check if your child has any of the following:

☐ Special Education Accommodations or a 504
☐ An Individual Education Plan (IEP)
☐ Diagnosed Learning Disability
☐ Receiving special services at school

HOUSING:

Would you consider your housing to be: ☐ Stable ☐ Unstable ☐ Currently Homeless

If unstable/homeless, please describe: _____

Do you live in housing with or owned by your employer? ☐Yes ☐No

FAMILY MENTAL HEALTH HISTORY:

Please identify if any members of your child's family have had a history of any of the following mental health/drug abuse/legal concerns (check all that apply):

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Youth										
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										
Paternal Aunt										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										

LEGAL INVOLVEMENT:

Is there a current custody case involving your child? ☐ Yes ☐ No If yes, please describe: _____

_____

History of CPS involvement: ☐ None ☐ Past ☐ Current If past or current, please describe: _____

_____

_____

OCCUPATIONAL INFORMATION:

Does your child have a job? ☐Yes ☐No If yes, what is their occupation and where do they work?

_____

Is your child free to quit their job if they choose to? ☐Yes ☐No If no, please explain:

_____

ALCOHOL/DRUG ASSESSMENT:

Does your child use tobacco or smokeless tobacco? ☐ Yes ☐ No ☐ Do not know

Does your child use alcohol and/or drugs? ☐ Yes ☐ No ☐ Do not know

To your knowledge, has your child ever used medications (prescription drugs or over-the-counter medication) recreationally? ☐ Yes ☐ No ☐ Do not know

To your knowledge, has your child ever overdosed or passed out on alcohol or other drugs? ☐ Yes ☐ No
If yes, when was the last overdose? _____

Has your child ever experienced problems related to their alcohol/drug use? ☐ Yes ☐ No
If yes, please describe: _____
If yes, have they continued to drink alcohol/use drugs? ☐ Yes ☐ No

HISTORY OF ABUSE/NEGLECT/TRAUMA:

Has your child ever been abused, neglected, assaulted, or experienced trauma? ☐ Yes ☐ No
If yes, please circle all that apply and briefly explain below:

Physical Abuse Sexual Abuse Psychological Abuse Robbery

Assault Dating Violence Domestic Violence Human Trafficking

DUI/DWI Crash Homicide Witnessed Domestic Violence

Other: _____
Brief Account: _____

HISTORY OF RACE-BASED TRAUMA:

Has your child ever been the victim of race-based trauma? ☐ Yes ☐ No
If yes, please circle all that may apply and briefly explain below:

Bullying Racist Experiences Oppression Discrimination Internalized Racism

Other: _____
Brief Account: _____

HISTORY OF SEXUAL ORIENTATION-BASED TRAUMA:

Has your child ever been the victim of sexual orientation-based trauma? ☐ Yes ☐ No

If yes, please circle all that may apply and briefly explain below:

Bullying Oppression Discrimination Internalized Homophobia

Other: _____

Brief Account: _____

HISTORY OF VIOLENCE:

Has your child ever been accused of abusing or assaulting someone? ☐ Yes ☐ No

If yes, please circle all that apply and briefly explain below:

Physical Abuse Sexual Abuse Psychological Abuse Robbery

Assault Dating Violence Domestic Violence Human Trafficking

DUI/DWI Crash Homicide

Other: _____

Brief Account: _____

Who does/can your child count on for support (please check all that apply)?

☐ Parents ☐ Boyfriend/Girlfriend ☐ Siblings ☐ Extended Family ☐ Friends ☐ Neighbors ☐ School Staff

☐ Church ☐ Pastor ☐ Therapist ☐ Group ☐ Community Services ☐ Doctor ☐ Other: _____

ADDITIONAL INFORMATION:

Please use the following section to list any additional information that you deem important/relevant:

_____

_____

_____

_____

INDIVIDUAL(S) COMPLETING ASSESSMENT:

Printed Name (primary person): _____ Date: _____

Signature: _____

Relationship to child: _____

Printed Name (secondary person): _____ Date: _____

Signature: _____

Relationship to child: _____

BIOPSYCHOSOCIAL ADDENDUM –For Internal Use Only

Original biopsychosocial reviewed by (counselor initials)_____ on (date) _____

Date: _____

Circle One: Additional Information Update to Existing Information

Brief Summary:

_____
_____
_____
_____
_____

Counselor Signature & Credentials: _____

Date: _____

Circle One: Additional Information Update to Existing Information

Brief Summary:

_____
_____
_____
_____
_____

Counselor Signature & Credentials: _____

Date: _____

Circle One: Additional Information Update to Existing Information

Brief Summary:

_____
_____
_____
_____
_____

Counselor Signature & Credentials: _____