

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: _____
Guardian (s) email address: _____	
Client/Child's D.O.B.: _____	Gender: Male / Female / Transgender / Non-Binary / Other : _____
Preferred Pronoun: He / She / They / Other: _____	
Client/Child's SS#: _____	

Primary Guardian Name(s): _____
Primary Guardian(s) Address: _____
Primary Guardian(s) Telephone Number(s): _____
Primary Guardian (s) Email Address: _____
Is there a custody agreement for the child you are seeking treatment for? If yes, please explain and provide copy: _____
Who has legal rights of the child you are seeking treatment for? _____
Client's Biological Mother's Name/Phone number and contact information (if known): _____
Client's Biological Father's Name/Phone number and contact information (if known): _____

**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  Internet  
 Other \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**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 checkmark 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, Grief Issues
- Lying
- Mood swings
- Nervousness (Worrying/Anxiety)
- 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

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- 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
- Sleep problems (Increased or decreased need to sleep)
- Other \_\_\_\_\_

**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, are these statements something that they have talked about recently? If yes to either question, 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:  
\_\_\_\_\_  
\_\_\_\_\_

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**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. 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. Does your child have any family members who are or have been incarcerated? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_
5. Does your child have any family members who have committed suicide? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_
6. 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. On average, how many hours of sleep does your child get per night?  
\_\_\_\_\_
4. 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?  
\_\_\_\_\_  
\_\_\_\_\_

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

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6. 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.

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7. 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.

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

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

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**SECTION 6: ADDICTION HISTORY:**

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

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2. How frequently is your child drinking alcohol?

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

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

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

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6. How frequently is your child using drugs?

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

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

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

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

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

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

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

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**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.

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

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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:

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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.

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

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\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

### **SECTION 7: TRAUMA HISTORY**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Has your child ever physically, sexually, emotionally or verbally abused another child(ren)? If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Has your child ever experienced or witnessed any other types of traumatic events in their life? For example, have they been involved in a natural disaster, witnessed domestic violence, been bullied at school, watched someone they care about die or be seriously injured, witnessed drug and alcohol use in the home, etc. If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. If your 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.

\_\_\_\_\_  
\_\_\_\_\_

5. Has your child ever experienced discrimination on the basis of your race, religion, age, gender, sexual orientation, disability, etc.? If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

### **SECTION 8: LEGAL ASSESSMENT**

1. Has your child ever been charged with a summary offense, misdemeanor, felony, etc.? If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

2. Does your child have any pending charges? If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

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3. Is your child currently on probation/parole? If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

**SECTION 9: FAMILY ASSESSMENT**

1. Where (City/State) was your child born and raised?

\_\_\_\_\_

2. Who raised your child? (Biological parents/Grandparents/Foster Care, etc.)

\_\_\_\_\_

3. Does your child have any brothers/sisters? If yes, please list names and ages.

\_\_\_\_\_  
\_\_\_\_\_

4. Are there any services/agencies involved with anyone living in your child's home (Children and Youth Services, Family-Based Treatment, Behavioral Health Rehabilitation Services, etc.)? If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

5. Please describe how your child was disciplined.

\_\_\_\_\_  
\_\_\_\_\_

6. How would you describe your child's childhood?

\_\_\_\_\_  
\_\_\_\_\_

7. How would you describe your child's current relationship with their family?

\_\_\_\_\_  
\_\_\_\_\_

**SECTION 10: 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.

\_\_\_\_\_  
\_\_\_\_\_

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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 11: 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 12: PERSONAL ASSESSMENT**

**Leisure Activity**

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?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Cultural Identity Aspects:** (Please complete if you feel comfortable)

1. What is your child's family nationality/ethnic background? \_\_\_\_\_

Primary language spoken:  English  Spanish  Other \_\_\_\_\_

2. If primary language spoken is not English, does your child speak/understand English? \_\_\_\_\_

3. Are there any cultural or special practices that may impact your child's attendance/participation in treatment?

\_\_\_\_\_  
\_\_\_\_\_

4. Is there anything about your child's culture that you would like us to know to best help you?

\_\_\_\_\_  
\_\_\_\_\_

**Sexuality and Gender:** (Please complete if you feel comfortable)

1. What is your child's identified gender? (Male / Female / Transgender / Non-Binary / Other)

\_\_\_\_\_  
\_\_\_\_\_

2. How does your child identify their sexual orientation?

\_\_\_\_\_  
\_\_\_\_\_

3. Is your child experiencing any conflict over their identified gender or sexual orientation? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**Spirituality Assessment: (Please complete if you feel comfortable)**

1. Does your child have a spiritual/religious preference? If yes, please explain:

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2. Is your child actively involved within your spiritual/religious community? If yes, please explain:

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3. Who or what about your child's spiritual/religious preferences provides your child with strength and hope?

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4. What type of spiritual/religious support would your child like, if any, while here?

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5. Have your child's spiritual beliefs helped them with their problems? If yes, please explain:

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**SECTION 13: EDUCATION**

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

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

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

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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.

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

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

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

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**SECTION 14: SOCIAL RELATIONSHIPS**

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

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

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

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

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

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**SECTION 15: 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.**

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Client/Child's Name \_\_\_\_\_

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

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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**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 \_\_\_\_\_