

**Child/Adolescent BioPsychoSocial Assessment
(for parent and/or child/adolescent to complete)**

Today's Date: _____

Child's Name: _____ Child's Age _____ Date of Birth: _____

Parent/Guardian Name _____

School Child Attends: _____ School Release Signed? __yes __no

What grade is your child in? _____

Top 3 Concerns/Reasons for Seeking Services: (Please note when these concerns first started for your child , ex: age 3 after attending a friend's birthday party)

Who resides in the home? (Please list names/ages/relationship to the child). Any Pets?
Parents/Guardians- What is your occupation?

How does everyone get along? _____

Here is a list of common symptoms – please feel free to circle those that concern you about your child.

Depression/Sadness	Withdrawn	Low Self Esteem	Loss of Interests
Self Injurious Behaviors	Poor Sleep Patterns/Nightmares	Poor Social Skills	Defiant/Uncooperative
Anger Problems	Aggression Towards Others	Drug/Alcohol Use	Over Sexualized Behaviors
Poor Self Control	Destruction of Property	Hyperactivity	Inattentive/Poor Focus
Excessive Fears/Worry	Bedwetting or Encopresis/Enuresis	Hallucinations/Delusions Or Dissociations	Regressive Traits/ Immature for Age
Physical Symptoms	Lying	Change in Grades	Change in Appetite

Has your child ever had counseling before? Y N Any psychiatric hospitalizations? Y N
If Yes please note where and the dates of service: _____

Any involvement in the legal system Y N On probation? Y N
If yes, please explain below;

Family Dynamics:

Family History of Mental Health Concerns: _____

Family History of Drug/Alcohol Concerns: _____

Who typically disciplines the child? _____
How does that discipline typically look in your household? (Circle those that apply)

Remove Privileges	Add Chores	Yell/Scream/Shout	Lecture
Time Out	Ignore	Discuss Situation with Child	Spank with Hand
Spank with Object	Send to Room (alone)	Other:	

Are you consistent with your discipline? _____

How does your child typically respond when disciplined? _____

Risk Assessment

Has your child ever had thoughts of harming his/herself? Y N
If yes – has your child had a plan to do so? _____
Has your child ever attempted to harm his/herself? Y N Attempted to harm others? Y N
Has you child ever intentionally harmed an animal/pet? Y N
Did you ever have to call Crisis Intervention for you child? Y N
If yes to any questions above, please explain below:

History of Substance Use/Abuse

Has your child used/are using the following (circle all that may apply/add other info as needed):

Alcohol	OTC med abuse	Inhalants	Cocaine	Caffeine
Rx med abuse	Heroin/opiates	Synthetic/Club drugs	Marijuana	Cigarettes
Hallucinogens	Other			

Received any drug/alcohol assessments or treatment? Y N If yes, where? _____

Medical Information

Is your child currently on any medications? Y N If yes please list below and who prescribes:

Please list any current medical issues, history of medical hospitalizations for medical issues or any histories of head injuries:

How was the pregnancy/delivery with the child? Any complications? Time spent in the NICU? Ongoing medical issues as a result?

Developmental Milestones: (Please note if your child was on time, delayed or early)

Speaking: ___ on time ___ early ___ delayed (at what age?) _____

Walking: ___ on time ___ early ___ delayed (at what age?) _____

Potty Trained: ___ on time ___ early ___ delayed (at what age?) _____

Females- menstruating? Y N Age at first period _____

Any ongoing issues with bathroom/bedwetting? _____ If yes please describe below:

Trauma History

Below is a list of common stressors for children. Please circle if your child has experienced any of the following and feel free to elaborate:

Sexual Abuse	Physical Abuse or Neglect	Emotional Abuse or Neglect	Witness to Domestic Violence
Sudden Loss of a Family Member (or Pet)	Incarcerated Family Member or other Abandonment	Frequent Moving or Homelessness	Witness to Community Violence
Alcohol or Drug Abuser in Household	Someone who is Chronically Depressed/Mentally Ill or Suicidal Living in the Household	Comments/Other:	

School History

Please note any issues experienced in the school setting (examples include: grades changing drastically, behavioral concerns at school, social difficulty, bullying, etc)

Is your child involved in any extra curricular activities either inside of school, church or outside of the school setting? (sports, music, clubs, youth groups, employed, etc).

What technology does your child have current access to? Please circle those that apply:

Smart Phone	Computer with Internet Access	Facebook Account	Twitter Account
Instagram Account	SnapChat Account	Video Game System(s): (which ones?)	
iPad	Other:		

How is this technology monitored in your home? _____

Do you have password access? _____ How does your child primarily communicate with their friends? _____

Have there been any issues with your child being bullied or bullying others online? Y N
If yes, please explain _____

Any other online issues? (communicating with strangers, etc) _____
If yes – please describe: _____

Additional Supports

Please make note of any additional supports your child has in his/her life that they have regular access to (grandparents, other family members, best friends, coaches, youth advisors, etc)

Strengths

Please tell us some of your child’s biggest strengths. What are the best things about him/her? _____

What are his/her favorite things to do for fun? _____

Is there anything else you would like us to know about your child?

Please stop here- the remaining part of the assessment form is for your therapist to complete.

Therapist Treatment Recommendations/Notes:

Provisional Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____ Highest in past year: _____

Next appt: _____

Assessment Done by: _____

Printed Name: _____