CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Demographics

Client Name:	**Date:**	
Current Address: Street City/State Zip Code	**Phone #:** ( ) -	
Date of Birth:	**Marital/Relationship Status:**	
Nation/Tribe/Ethnicity:		
Primary language of client:		**Secondary:**
Referral Source:		**Phone:**
Emergency Contact:		**Phone:**

Family Relationships

Does the client have any children?

Name	Age	Date of Birth	Sex	Custody? Y/N	Lives With?	Additional Information

Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)

Name	Age	Sex	Relationship	Additional Information
Primary language of household/family:				**Secondary:**

Family History

Family History of (select all that apply):

	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol/Substance Abuse						
History of Completed Suicide						
History of Mental Illness/Problems such as:						
Depression						
Schizophrenia						
Bipolar Disorder						
Alzheimer's						
Anxiety						
Attention Deficit/Hyperactivity						
Learning Disorders						
School Behavior Problems						
Incarceration						
Other						
Comments:						

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Critical Population (choose all that apply)

Funding Source	Residential	Legal Involvement
☐ Food Stamp Recipient	☐ Homeless	☐ Protective Services (APS/CPS)
☐ TANF Recipient	☐ Shelter Resident	☐ Court Ordered Services
☐ SSI Recipient	☐ Long Term Care Eligibility	☐ On Probation
☐ SSDI Recipient	☐ Long Term Care Resident	☐ On Parole
☐ SSA (retirement) Recipient		☐ On Pre-Release
☐ Other Retirement Income	**Disability**	☐ Mandatory Monitoring
☐ Medicaid Recipient	☐ Physical Disability	
☐ Medicare Recipient	☐ Severely Mentally Ill	**Other**
☐ General Assistance	☐ SED	☐ Currently pregnant
	☐ Developmentally Disabled	☐ Woman w/dependents
	☐ Chronically Mentally Ill	
	☐ Regional Behavioral Health Authority	

Contact Information
(Secure consents for agency contacts, when possible)

Name of Caseworker	Agency	Phone number

Client's/Family's Presentation of the Problem:

Client's/Family's Expected Outcome:

Physical functioning

Allergies (Medication & Other):

Current Medical Conditions:

Current Medications (include herbs, vitamins, & over-the-counter):

Past Medications:

Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including RTC, group home, therapeutic foster care, aftercare, inpatient psychiatric, outpatient counseling):

Dates	Inpt/Outpt	Location	Reason	Completed? Y/N

Surgeries:

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Pain Questionnaire

Pain Management: Is the client in pain now? ☐ Yes ☐ No
If yes, ask client to rate the pain on a scale of 1-10 (with 10 being the severest) and enter score here

Is the client receiving care for the pain? ☐ Yes ☐ No
If no, would the client like a referral for pain management? ☐ Yes ☐ No

Nutrition

Nutritional Status: Current Weight Current Height BMI	
Appetite: ☐ Good ☐ Fair ☐ Poor, please explain below	
☐ Recently gained/lost significant weight	☐ Binges/overeats to excess
☐ Restricts food/Vomits/over-exercises to avoid weight gain	☐ Special dietary needs
☐ Hiding/hording food	☐ Food allergies
Comments	

Child/Adolescent Growth & Development

During pregnancy, did the biological mother have any of the following (select all that apply)?			
☐ Amniocentesis	☐ Anemia	☐ Diabetes Melllitus	
☐ Emotional Problems	☐ Excessive weight gain	☐ German Measles	
☐ High blood pressure	☐ High fever	☐ Kidney problems	
☐ No prenatal care	☐ Placenta Previa	☐ Premature labor	
☐ Vaginal bleeding	☐ Vaginal infection	☐ Other infection	
☐ Unknown	☐ Other:		
During pregnancy, did the mother use any of the following (select all that apply)?			
☐ Tobacco	☐ Alcohol	☐ Street Drugs	☐ Unknown
Comments (frequency and intensity of use, participation in treatment, birth defects or malformations due to drug/alcohol use among siblings):			
Any problems with labor &/or delivery?	**Apgar Scores?**		
Did the baby have any of the following after delivery (select all that apply)?			
☐ Anemia	☐ Apnea	☐ Birth defects	☐ Blood transfusions
☐ Bradycardia	☐ Cord around neck	☐ Eye problems	☐ Fever/low temperature
☐ Hernia	☐ Hydrocephalus	☐ Infection	☐ Intensive Care
☐ Intracranial bleed	☐ Jitteriness	☐ Physical injury	☐ Seizures
☐ Surfactant	☐ Trouble breathing	☐ Trouble sucking	☐ 1 of multiples (twin, etc)
☐ Use of Oxygen	☐ Ventilator	☐ Yellow Jaundice	☐ Other:
Developmental Milestones – please select any that the client did late or is still having trouble with:			
☐ Rolling Over (2-6 months)	☐ Sitting (6-12 months)	☐ Standing (8-16 months)	
☐ Walking (8-16 months)	☐ Engaging peers (24-36 months)	☐ Toileting (24-36 months)	
☐ Dressing self (24-36 months)	☐ Feeding Self	☐ Sleeping alone	
☐ Tolerating separation	☐ Playing cooperatively	☐ Speaking	
Are immunizations up to date? ☐ Yes ☐ No			

Has the client had any of the following (select all that apply)?				
Blood Disorders:	☐ Anemia	☐ Bleeding	☐ Bruising	
Brain Disorders:	☐ Confusion	☐ Headaches	☐ Coordination Problems	
	☐ Muscle Weakness	☐ Staring	☐ Tremors	
	☐ Tics (motor/vocal)	☐ Head Injuries	☐ Seizures	
GI Problems:	☐ Constipation	☐ Diarrhea	☐ Soiling	☐ Vomiting
Heart/Lung Problems:	☐ Asthma	☐ Chest Pain	☐ Murmur	☐ Surgery ☐ Congenital Heart Disease
Hormone Problems:	☐ Obesity	☐ Thyroid	☐ Early Puberty	☐ Late Puberty
Infections:	☐ Chicken Pox	☐ Measles	☐ Sinus infections	
☐ Ear infections	☐ Meningitis	☐ Whooping Cough	☐ Encephalitis	
☐ Mumps	☐ High fevers	☐ Pneumonia	☐ Other:	
Injuries:	☐ Broken Bones	☐ Stitches		
Kidney Problems:	☐ Bed wetting	☐ Daytime wetting	☐ Infections	
Muscle/Bone Problems:	☐ Scoliosis	☐ Spasticity	☐ Other:	
Poisoning:	☐ Chemicals	☐ Lead	☐ Other:	
Sensory Problems:	☐ Hearing	☐ Tactile	☐ Vision	
Sexual Problems:	☐ Birth Control	☐ Masturbation	☐ Promiscuity	
Skin Disorders:	☐ Acne	☐ Birth Marks	☐ Eczema	☐ Hair Loss

Social

Supportive Social Network? (Rate the network using a scale of **1** Weak to **5** Strong)			
Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	
What percentage of this network are substance-abusing?			%
Comment:			

Living Situation:			
☐ Housing Adequate	☐ Housing Dangerous	☐ Housing Overcrowded	☐ Homeless
☐ Dependent Upon Others	☐ Incarcerated	☐ Ward of State/Tribal Court	
Additional Information:			

Employment: Currently Employed?			
☐ **Yes**	**Employer**	**Length of Employment**	
☐ Satisfied	☐ Dissatisfied	☐ Supervisor Conflict	☐ Co-worker Conflict
☐ **No**	**Last Employer:**	**Reason for Leaving:**	
☐ **Never Employed**	☐ **Disabled**	☐ **Student**	☐ **Unstable Work History**

Family Financial Situation:		
Presence or absence of financial difficulties: (Fields below are optional)		
☐ No Current Problems	☐ Large Indebtedness	☐ Relationship Conflicts Over Finances
☐ Impulsive Spending	☐ Poverty or Below	☐ Financial Difficulties

Family's Source of Income (choose all that apply)				
Employed:	☐ Full-time ☐ Part-time ☐ Seasonal ☐ Temporary ☐ Self-Employed	Unemployed: ☐ Actively seeking work ☐ Not looking for work		☐ Public Assistance
☐ Retirement	☐ SSD	☐ SSDI	☐ SSI	
☐ Medical Disability via Employer		☐ Other:		

Sexual Orientation:	
☐ Heterosexual	☐ Bisexual
☐ Homosexual	☐ Transgendered
☐ N/A at this time	Comment:

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Family Social History

Describe family relationships & desire for involvement in the treatment process:
Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive)

Legal Status Screening

Past or current legal problems (select all that apply)?		
☐ None	☐ Gangs	☐ DUI/DWI
☐ Arrests	☐ Conviction	☐ Detention
☐ Jail	☐ Probation	☐ Other
If yes to any of the above, please explain:		
Any court-ordered treatment?	☐ Yes (explain below)	☐ No
Ordered by	**Offense**	**Length of Time**

Child/Adolescent Educational Assessment

Current educational setting:			
☐ Public	☐ Tribal	☐ Boarding (starting at age)	☐ Charter
☐ Private	☐ Home	☐ BIA	☐ Vocational
☐ Alternate	☐ GED	☐ College	☐ Other

Current grade level: ☐ **Skipped a grade or** ☐ **been held back?**
Any testing for an IEP (Individualized Education Plan)? ☐ Yes ☐ No
History of /or current placement in special education? **How many hours per day?**
For learning problems? ☐ Yes ☐ No **For behavior problems?** ☐ Yes ☐ No
History of hyperactivity at school? ☐ Yes ☐ No Comment:
Ever been expelled or suspended? ☐ Yes ☐ No Reason:
School attendance problems: ☐ Yes ☐ No Comments:
Other education-related concerns:

Leisure & Recreation

Which of the following does the client do? (Select all that apply)			
Spend Time with Friends		Sports/Exercise	
Classes		Dancing	
Time with Family		Hobbies	
Work Part-Time		Watch Movies/TV	
Go "Downtown"		Stay at Home	
Listen to Music		Spend Time at Clubs/Bars	
Go to Casinos		Other:	
What limits the client's leisure/recreational activities?			

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Functional Assessment

Is client able to care for him/herself? ☐ Yes ☐ No If No, please explain:

Living Situation:

☐ Housing Adequate	☐ Housing Dangerous	☐ Housing Overcrowded	☐ Homeless
☐ Dependent Upon Others	☐ Incarcerated	☐ Ward of State/Tribal Court	

Additional Information:

Uses or Needs assistive or adaptive devices (select all that apply):

☐ None	☐ Glasses	☐ Walker	☐ Braille
☐ Hearing Aids	☐ Cane	☐ Crutches	☐ Wheelchair
☐ Translated Written Information	☐ Translator for Speaking	☐ Other:	

Psychological

History of Depressed Mood: ☐ Yes ☐ No

History of irritability, anger or violence (tantrums, hurts others, cruel to animals, destroys property):

Sleep Pattern: Number of hours per day Time to onset of sleep?

☐ Normal ☐ Sleeping too much ☐ Sleeping too little

Ability to Concentrate: ☐ Normal ☐ Difficulty concentrating

Energy Level: ☐ Low ☐ Average/Normal ☐ High

History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal)? Select all that apply

☐ Intrusive memories, thoughts, perceptions	☐ Nightmares	☐ Flashbacks
☐ Avoiding thoughts, feelings, conversations	☐ Numbing/detachment	☐ Restricted display of emotions
☐ Avoiding people, places, activities	☐ Poor sleep	☐ Irritability
☐ Hypervigilance	☐ Other:	

Any additional information:

Bereavement/Loss & Spiritual Awareness

Please list significant losses, deaths, abandonments, traumatic incidents:

Spiritual/Cultural Awareness & Practice

Knowledgeable about traditions, spirituality, or religion? ☐ Yes ☐ No Comment:

Practices traditions, spirituality, or religion? ☐ Yes ☐ No Comment:

How does client describe his/her spirituality?

Does client see a traditional healer? ☐ **Yes** ☐ **No** **Comment:**

Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, medical, educational) or exploitation?
If yes, please explain.

Has client been abused at any time in the past or present by family, significant others, or anyone else?) ☐ No ☐ Yes, explain:

Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal Putdowns			
Being threatened			
Made to feel afraid			
Pushed			
Shoved			
Slapped			
Kicked			
Strangled			
Hit			
Forced or coerced into sexual activity			
Other			

Was it reported? ☐ Yes ☐ No

To whom?

Outcome

Has client ever witnessed abuse or family violence? ☐ No ☐ Yes, explain:

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Behavioral Assessment

Abuse/Addiction – Chemical & Behavioral				
Drug	**Age First Used**	**Age Heaviest Use**	**Recent Pattern of Use (frequency & Amount, etc)**	**Date Last Used**
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, speed, amphetamines, etc)				
Methamphetamine				
Inhalants (gas, paint, glue, etc)				
Hallucinogens (LSD, PCP, mushrooms, etc)				
Opioids (heroin, narcotics, methadone, etc)				
Sedative/Hypnotics (Valium, Phenobarb, etc)				
Designer Drugs/Other (herbal, Steroids, cough syrup, etc)				
Tobacco (smoke, chew)				
Caffeine				
Ever injected Drugs?	☐ Yes	☐ No	**If Yes, Which ones?**	

Drug of Choice?

Consequences as a Result of Drug/Alcohol Use (select all that apply)

☐ Hangovers	☐ DTs/Shakes	☐ Blackouts	☐ Binges
☐ Overdoses	☐ Increased Tolerance (need more to get high)	☐ GI Bleeding	☐ Liver Disease
☐ Sleep Problems	☐ Seizures	☐ Relationship Problems	☐ Left School
☐ Lost Job	☐ DUIs	☐ Assaults	☐ Arrests
☐ Incarcerations	☐ Homicide	☐ Other:	

Longest Period of Sobriety?	**How long ago?**

Triggers to use (list all that apply):

Has client traded sex for drugs? ☐ No ☐ Yes, explain:

Has client been tested for HIV? ☐ Yes ☐ No

If yes, date of last test:	**Results:**

Has client had any of the following problem gambling behaviors? Select all that apply:

☐ Gambled longer than planned	☐ Gambled until last dollar was gone
☐ Lost sleep thinking of gambling	☐ Used income or savings to gamble while letting bills go unpaid
☐ Borrowed money to gamble	☐ Made repeated, unsuccessful attempts to stop gambling
☐ Been remorseful after gambling	☐ Broken the law or considered breaking the law to finance gambling
☐ Other:	☐ Gambled to get money to meet financial obligations

Risk Taking/Impulsive Behavior (current/past) – select all that apply:

☐ Unprotected sex	☐ Shoplifting	☐ Reckless driving
☐ Gang Involvement	☐ Drug Dealing	☐ Carrying/using weapon
☐ Other:		

 Revised 5/3/06

Mental Status Exam

Category	Selections			
GENERAL OBSERVATIONS				
Appearance	☐ Well groomed	☐ Unkempt	☐ Disheveled	☐ Malodorous
Build	☐ Average	☐ Thin	☐ Overweight	☐ Obese
Demeanor	☐ Cooperative	☐ Hostile	☐ Guarded	☐ Withdrawn
	☐ Preoccupied	☐ Demanding		☐ Seductive
Eye Contact	☐ Average	☐ Decreased		☐ Increased
Activity	☐ Average	☐ Decreased		☐ Increased
Speech	☐ Clear	☐ Slurred	☐ Rapid	☐ Slow
	☐ Pressured	☐ Soft	☐ Loud	☐ Monotone
	Describe:			
THOUGHT CONTENT				
Delusions	☐ None Reported	☐ Grandiose	☐ Persecutory	☐ Somatic
	☐ Bizarre	☐ Nihilist		☐ Religious
	Describe:			
Other	☐ None Reported	☐ Poverty of Content	☐ Obsessions	☐ Compulsions
	☐ Phobias	☐ Guilt	☐ Anhedonia	☐ Thought Insertion
	☐ Ideas of Reference		☐ Thought Broadcasting	
	Describe:			
Self Abuse	☐ None Reported		☐ Self Mutilization	
	☐ Suicidal (assess lethality if present)		☐ Intent	☐ Plan
Aggressive	☐ None Reported	☐ Aggressive (assess lethality of present)		
	☐ Intent		☐ Plan	
PERCEPTION				
Hallucinations	☐ None Reported	☐ Auditory		☐ Visual
	☐ Olfactory	☐ Gustatory		☐ Tactile
	Describe:			
Other	☐ None Reported	☐ Illusions	☐ Depersonalization	☐ Derealization
THOUGHT PROCESS				
☐ Logical	☐ Goal Oriented	☐ Circumstantial	☐ Tangential	
☐ Loose	☐ Rapid Thoughts	☐ Incoherent	☐ Concrete	
☐ Blocked	☐ Flight of Ideas	☐ Perserverative	☐ Derailment	
Describe:				
MOOD				
☐ Euthymic	☐ Depressed	☐ Anxious		
☐ Angry	☐ Euphoric	☐ Irritable		
AFFECT				
☐ Flat	☐ Inappropriate	☐ Labile	☐ Blunted	
☐ Congruent with Mood	☐ Full	☐ Constricted		
BEHAVIOR				
☐ No behavior issues	☐ Assaultive	☐ Resistant		
☐ Aggressive	☐ Agitated	☐ Hyperactive		
☐ Restless	☐ Sleepy	☐ Intrusive		
MOVEMENT				
☐ Akasthisia	☐ Dystonia	☐ Tardive Dyskinesia	☐ Tics	
Describe:				
COGNITION				
Impairment of:	☐ None Reported		☐ Orientation	☐ Memory
	☐ Attention/Concentration		☐ Ability to Abstract	
	Describe:			
Intelligence Estimate	☐ Mental Retardation	☐ Borderline	☐ Average	☐ Above Average
IMPULSE CONTROL		☐ Good	☐ Poor	☐ Absent
INSIGHT		☐ Good	☐ Poor	☐ Absent
JUDGMENT		☐ Good	☐ Poor	☐ Absent

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

RISK ASSESSMENT				
Risk to Self	☐ Low	☐ Medium	☐ High	☐ Chronic
Risk to Others	☐ Low	☐ Medium	☐ High	☐ Chronic

Serious current risk of any of the following: (Immediate response needed)	
Abuse or Family Violence ☐ Yes ☐ No	**Abuse or Family Violence** ☐ Yes ☐ No
Psychotic or Severely Psychologically Disabled ☐ Yes ☐ No	
Is there a handgun in the home? ☐ Yes ☐ No	**Any other weapons?** ☐ Yes ☐ No
Plan:	
Safety Plan Reviewed ☐ Yes ☐ No	

Diagnoses and Interpretive Summary

Biopsychosocial formulation	
DSM IV-TR Provisional Diagnoses	
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	
Treatment Acceptance/Resistance	
Client accepts problem? ☐ No ☐ Yes Comment:	
Client recognizes need for treatment? ☐ No ☐ Yes Comment:	
Client minimizes or blames others? ☐ No ☐ Yes Comment:	
External motivation is primary? ☐ No ☐ Yes Comment:	

Strengths/Resources (enter score if present) **1 = Adequate, 2 = Above Average, 3 = Exceptional**

Family Support	Social Support Systems	Relationship Stability
Intellectual/Cognitive Skills	Coping Skills & Resiliency	Parenting Skills
Socio-Economic Stability	Communication Skills	Insight & Sensitivity
Maturity & Judgment Skills	Motivation for Help	Other:

Comments:

Describe appropriateness & level of need for the family's participation:

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Preliminary Treatment Plan & Referrals

Preliminary Biopsychosocial Treatment Plan
Biological:
Psychological:
Social/Environmental:

Referrals			
☐ Psychiatrist	☐ Psychologist	☐ Medical Provider	☐ Spiritual Counselor
☐ Benefits Coordinator	☐ Nutritionist	☐ Rehabilitation	☐ Vocational Counselor
☐ Social Worker	☐ Community Agency:		☐ Other:

Physical Fitness (Optional)

Physical Activity (please select one of the following based on activity level for the past month):

☐ Avoids walking or exertion, e.g. always uses elevator, drives whenever possible instead of walking.

☐ Walks for pleasure, routinely uses stairs, occasionally exercises sufficiently to cause heavy breathing or perspiration.

Participates regularly in recreation or work requiring **modest physical activity** such as golf, horseback riding, calisthenics, gymnastics, table tennis, bowling, weight lifting, and yard work.

- ☐ 10-60 minutes per week
- ☐ More than one hour per week

Participates regularly in **heavy physical exercise,** such as running, jogging, swimming, cycling, rowing, skipping rope, running in place or engaging in vigorous aerobic activity such as tennis, basketball or handball.

- ☐ Runs less than a mile a week or engages in other exercise for less than 30 minutes per week
- ☐ Runs 1-5 miles per week or engages in other exercise for 30-60 minutes per week
- ☐ Runs 5-10 miles per week or engages in other exercise for 1-3 hours per week
- ☐ Runs more than 10 miles per week or engages in other exercise for more than 3 hours per week