CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Demographics Box

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:**

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	

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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 Realm	**Yes**	**No**
Client acknowledges he/she has caused damage to his/her body by abusing drugs, alcohol or food. ***If yes, complete Behavioral Assessment***		
Client understands the connection between emotions, life stressors, sense of self and the effect these elements have on physical health.		
Client manages his/her anger effectively and does not inflict pain on himself/herself or others.		
Client engages in activities designed to maintain physical health. ***Optional – Physical Fitness***		
Allergies (Medication and Other):		
Comments:		

Nutritional Screening

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:	

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

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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

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:		

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?			

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:

Emotional Realm	**Yes**	**No**
Client has an understanding of his/her special relationship to Mother Earth.		
Client has an understanding of his/her relationship with Father Sky.		
Client has a sense of connectedness to the entire universe.		
Client is able to acknowledge all fears, desires, emotions, and feelings of distress & cares for his/her own spirit.		

Additional Information:

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Child/Adolescent Educational Assessment

Current educational setting:

☐ Public	☐ Tribal	☐ Boarding	☐ Charter
☐ Private	☐ Home	☐ BIA	☐ Vocational
☐ Alternate	☐ GED	☐ College	☐ Other

Current grade level: ☐ **Ever skipped a grade or** ☐ **been held back?** I

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:

Functional Assessment

Functional Assessment:

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

Living Situation:

☐ Housing Adequate	☐ Housing Dangerous	☐ Ward of State/Tribal Court	☐ Dependent on Others
☐ Housing Overcrowded	☐ Incarcerated	☐ Homeless	☐ At Risk of Homelessness

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:	

Does the client have a history of falls? ☐ Yes ☐ No Explain:

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

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)**

Spiritual Self	**Yes**	**No**
Client demonstrates a willingness to seek out new persons, places and experiences.		
Client expresses a desire to make a positive life change.		
Client seeks to balance his/her rights, needs and desires with those of others in order to achieve harmony.		
Client desires personal harmony, balance and freedom.		
Client seeks to strengthen his prayer life/belief system.		
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? ☐ Yes ☐ No
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:

Mental/Introspective Thought	Yes	No
Client believes that he is speaking honestly with him/herself.		
Client looks at both problems & accomplishments as an indicator of his/her sense of self		
Client examines the ways in which he/she has tried to manipulate, control or manage the lives of others.		
Client acknowledges that changes in his/her life must start with him/her.		

Additional Information:

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:

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

CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

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

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:

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