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Child/Adolescent Biopsychosocial Questionnaire

Today's Date: _____

Child's Name: _____ Child's Age: _____

Date of Birth: _____ Form completed by: _____

Presenting Problem

What are the main concerns that bring you to therapy?

_____
_____
_____
_____
_____
_____
_____
_____

How long has this been a concern? _____
_____
_____

What strategies have been used to address the problem?_____
_____
_____
_____
_____

What are your goals for therapy?

_____
_____
_____
_____
_____

Please review the following list of common symptoms and circle or mark those that are of concern for your child.

Depression/Sadness ☐	Withdrawn ☐	Low Self Esteem ☐	Loss of Interests ☐
Self Injurious Behaviors ☐	Poor Sleep Patterns/Nightma ☐	Poor Social Skills ☐	Defiant/Uncooperative ☐
Anger Problems ☐	Aggression Towards Others ☐	Drug/Alcohol Use ☐	Over Sexualized Behavior ☐
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 ☐

Traumatic childhood events such as abuse, neglect, and witnessing experiences like crime, parental conflict, mental illness, and substance abuse can result in long-term negative effects on learning, behavior and health (from the ACES study).

Sudden loss of a family member or pet ☐	Frequent moving ☐	Planned or unplanned me away from child ☐	Parental conflict/divorce ☐
Witness to community violence ☐	Natural disasters ☐	Witness to domestic violence ☐	Someone who is chronically medically ill ☐
Someone who is chronically depressed or suicidal living in the household ☐	Alcohol or drug abuser in the household ☐	Incarcerated family member ☐	Life threatening events or accidents ☐
Physical abuse ☐	Emotional buse/Neglect ☐	Sexual abuse ☐	Military deployment ☐

Additional information about circled concerns:_____

_____

_____

_____

_____

_____

Risk Assessment

Risk Assessment	Yes/No	Explain
Has your child ever made suicidal statements or made suicide attempts?	Yes	
Has your child ever intentionally harmed an animal/pet?	Yes	
Has your child ever engaged in self-harming behavior?	Yes	
Do you have concerns that your child may be using drugs or alcohol?	Yes	

Past Counseling/Therapeutic Services

Dates received/attended	Provider/Agency	Phone/Address	Diagnosis (if assigned)

Has anyone in your family or extended family ever had psychotherapy or counseling before?
Yes/No _____
_____

Family Information

Please list family members that live in the home with child (and pets):

Name	Relationship	Age	Describe their relationship with child.

Other immediate family members that live outside of the home (i.e., parents or siblings):

_____
_____
_____

Indicate primary caregivers' relationship status:

- ◯ Married
- ◯ Single
- ◯ Partnered
- ◯ Separated
- ◯ Divorced

Are there family members or others that you consider part of your family's support system?

_____
_____
_____

History of CPS or alternate placements (kinship, foster, group home)? Yes/No Please describe.

_____
_____

Does your family actively participate in religion/spirituality? Yes/No (If yes, where?) Is your child involved in the youth program?_____
_____

Medical History

Primary Care Doctor or Pediatrician (Name/Address/Phone Number):_____
_____
_____

Please list any medications your child is taking at this time:

Name of medication	Dosage	Reason for taking	Prescribing Physician

Is your child up to date on their vaccinations? _____
Date of last physical exam: _____

Has your child ever been bitten by a tick? _____
Any history of head injuries/allergies/surgeries?_____

Please describe any past and present medical concerns or serious illnesses:_____
_____
Are you aware of any sensory processing issues that your child has? Yes/No (Please describe.)
_____

Are there any extended family members who have been diagnosed with a mental health disorder? Identify family member's relationship to your child and the medical condition:
_____
_____
_____
_____

Is there any family use of alcohol or drugs? Yes/No (Please describe).
_____
_____
_____

Developmental History

Were kids always a part of your life plan? _____
How many total pregnancies have you had?_____
Any history of infertility, miscarriages, and/or stillborn losses? _____
Term of pregnancy: _____ months Birth weight:_____

Were there any complications with the pregnancy or delivery? (i.e., time spent in the NICU? Ongoing medical issues as a result?) Yes/No (Please describe.) _____
_____

During pregnancy, was there any use of drugs/alcohol, exposure to domestic violence, major illnesses/accidents, or significant stressors? Yes/No (Please describe.) _____
_____

Please list approximate ages when child reached the following milestones:

Speaking	
Walking	
Potty Trained	

Any problems with feeding or sleeping? Yes/No (Please describe)_____
_____

	Concerns regarding development or peers?	Significant stressors?	Temperament of child?	Peer/teacher relations?
Ages 0-3				
Ages 4-6				
Ages 7-12				
Ages 13-18				

What technology/social media does your child have current access to? _____
_____
_____

How is technology monitored in the home? _____
_____
_____

Any issues of bullying either online or in school? (communicating with strangers, etc)
_____
_____

School Information

Current school and grade:_____

What schools has your child attended in the past? _____
_____

Has your child been identified as having a learning disorder? Any accommodations for learning? Yes/No (IEP, 504, OT/PT, speech)
_____
_____

Has your child ever received speech therapy or occupational therapy? Yes/No (If yes, please describe.)_____

_____

Do you have concerns about your child's behavior at school?_____

_____

What activities or clubs is your child involved in?_____

_____

Child Management

Mark the methods do you generally use for discipline of your children?

Time out_☐_ Discuss with child_☐_ Lecture_☐_ Remove privileges_☐_

Add chores_☐_ Spank_☐_ Send to room (alone)_☐_

Are you consistent with your discipline? Yes/No (If no, please describe.) _____

_____

How does your child typically respond when disciplined? _____

_____

What do you consider to be your family strengths? What do you feel that you need to improve or change as a family?_____

_____

_____

_____

Additional Information

What are some of the strengths and positive qualities of your child?_____

_____

_____

_____

_____

Is there any other information that I should know regarding your child or family?_____

_____

_____

_____

_____