

# Child & Adolescent Psychiatry Consulting LLC

## Behrend Psychology Consultants

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### Child/Adolescent Biopsychosocial History Form

Name of child/adolescent/: \_\_\_\_\_ Date: \_\_\_\_\_

Birth date: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Sex: \_\_\_ F \_\_\_ M

#### PRESENTING PROBLEM

Please note how often each of the following occurs for this child/adolescent using the following numbers.

0 = Never    1 = Rarely    2 = Sometimes    3 = Often    4 = Always

- |  |   |
|--|---|
| <input type="checkbox"/> Picks at things (nails, fingers, hair, clothing)                  | <input type="checkbox"/> Talks back to authority figures (has "an attitude")                          |
| <input type="checkbox"/> Has problems with making and keeping friends                      | <input type="checkbox"/> Excitable, impulsive   |
| <input type="checkbox"/> Wants to run things   | <input type="checkbox"/> Sucks or chews (thumb, clothing, blankets, etc.)                             |
| <input type="checkbox"/> Cries easily/often  | <input type="checkbox"/> Emotionally reactive   |
| <input type="checkbox"/> Has a "chip on his/her shoulder"                                  | <input type="checkbox"/> Tendency to daydream   |
| <input type="checkbox"/> School problems (academic, behavioral, social)                    | <input type="checkbox"/> Always squirming, restless, and moving around                                |
| <input type="checkbox"/> Experiences fear and anxiety in new situations/meeting new people | <input type="checkbox"/> Breaks things, destructive   |
| <input type="checkbox"/> Does not follow rules   | <input type="checkbox"/> Lies, makes up stories   |
| <input type="checkbox"/> Shy, does not assert self   | <input type="checkbox"/> Gets into trouble more than others the same age                              |
| <input type="checkbox"/> Denies mistakes, is defensive                                     | <input type="checkbox"/> Has problems with speech (stuttering, hard to understand, baby talk)         |
| <input type="checkbox"/> Steals  | <input type="checkbox"/> Blames others for mistakes   |
| <input type="checkbox"/> Disrespectful   | <input type="checkbox"/> Argumentative  |
| <input type="checkbox"/> When hurt or angered by someone, holds a grudge                   | <input type="checkbox"/> Pouts and sulks  |
| <input type="checkbox"/> Worries unnecessarily   | <input type="checkbox"/> Develops stomachache or headache when stressed                               |
| <input type="checkbox"/> Emotionally sensitive, easily hurt                                | <input type="checkbox"/> Does not finish tasks  |
| <input type="checkbox"/> Cruel and insensitive   | <input type="checkbox"/> Bullies others   |
| <input type="checkbox"/> Easily distracted   | <input type="checkbox"/> Clingy, in need of constant reassurance                                      |
| <input type="checkbox"/> Rapid mood changes  | <input type="checkbox"/> Frequent headaches or stomachaches   |
| <input type="checkbox"/> Power struggles with authority                                    | <input type="checkbox"/> Fights a lot, creates conflicts  |
| <input type="checkbox"/> Does not get along well with siblings                             | <input type="checkbox"/> Childish or immature (wants help when should be able to do it independently) |
| <input type="checkbox"/> Easily frustrated   | <input type="checkbox"/> Perfectionism interferes with trying new things                              |
| <input type="checkbox"/> Problems with sleep   | <input type="checkbox"/> Problems with eating   |
| <input type="checkbox"/> Has bowel problems  | <input type="checkbox"/> Vomiting, nausea, or other complaints of pain or physical distress           |
| <input type="checkbox"/> Feels he/she is treated differently in family than siblings       | <input type="checkbox"/> Passive, gets pushed around  |
| <input type="checkbox"/> Self-centered, brags, little understanding of others              | <input type="checkbox"/> Irritable, cranky  |
| <input type="checkbox"/> Temper outbursts  | <input type="checkbox"/> Withdrawn, isolates self   |
| <input type="checkbox"/> Clumsy, problems with physical coordination                       | <input type="checkbox"/> Short attention span   |
| <input type="checkbox"/> Undependable  | <input type="checkbox"/> Stubborn   |
| <input type="checkbox"/> Mean to others  | <input type="checkbox"/> Trouble with the law   |
| <input type="checkbox"/> Runs away   | <input type="checkbox"/> Cuts, burns or otherwise hurts self physically                               |
| <input type="checkbox"/> Head banging  | <input type="checkbox"/> Rocking  |
| <input type="checkbox"/> Shy, timid  | <input type="checkbox"/> Sets fires   |
| <input type="checkbox"/> Concerns regarding sexual behavior(s)                             | <input type="checkbox"/> Wets the bed   |
| <input type="checkbox"/> Soils pants   | <input type="checkbox"/> Alcohol use  |
| <input type="checkbox"/> Use of recreational drug(s)                                       | <input type="checkbox"/> Suicidal thoughts/talk   |
| <input type="checkbox"/> Intense, abnormal, or illogical fears                             |   |

Describe: \_\_\_\_\_

Strange behavior/thoughts

Describe: \_\_\_\_\_

How long have these problems been occurring? \_\_\_\_\_

What happened that makes you seek help at this time? \_\_\_\_\_

How serious do you perceive the problem to be? \_\_\_ mild \_\_\_ moderate \_\_\_ severe

How serious does your child/adolescent perceive the problem to be? \_\_\_ mild \_\_\_ moderate \_\_\_ severe

**In regard to the problem:**

What changes would you like to see in your child/adolescent? \_\_\_\_\_

What changes would you like to see in yourself? \_\_\_\_\_

What changes would you like to see in your family? \_\_\_\_\_

**CURRENT FAMILY SITUATION**

Mother's name: \_\_\_\_\_ Stepmother? \_\_\_ Yes \_\_\_ No

Address: \_\_\_\_\_

How often is this person in contact with this child/adolescent? \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How long with present employer? \_\_\_\_\_ Highest grade completed: \_\_\_\_\_

Father's name: \_\_\_\_\_ Stepfather? \_\_\_ Yes \_\_\_ No

Address: \_\_\_\_\_

How often is this person in contact with this child/adolescent? \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How long with present employer? \_\_\_\_\_ Highest grade completed: \_\_\_\_\_

Does this child/adolescent have any other parent(s)/stepparent(s)? \_\_\_ Yes \_\_\_ No

If yes, please provide the following information:

Name: \_\_\_\_\_

Relationship to this child/adolescent: \_\_\_\_\_ Home phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to this child/adolescent: \_\_\_\_\_ Home phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Marital History of Parents**

Natural parents: \_\_\_ married when \_\_\_\_\_ age when married: mother \_\_\_\_\_ father \_\_\_\_\_

\_\_\_ separated when \_\_\_\_\_

\_\_\_ divorced when \_\_\_\_\_

\_\_\_ deceased when \_\_\_\_\_ Mother and/or Father (please circle)

Step-parents \_\_\_ married when \_\_\_\_\_

Was this child/adolescent adopted? \_\_\_ Yes \_\_\_ No

If yes, please provide the following information.

Adoption source: \_\_\_\_\_

Age of child/adolescent when first placed in this home: \_\_\_\_\_ Date of legal adoption: \_\_\_\_\_

What has the child/adolescent been told about his/her adoption? \_\_\_\_\_

**LIVING ARRANGEMENTS**

Number of moves to new residences in child/adolescent's life: \_\_\_\_\_

If one or more, please describe the circumstances that precipitated the move(s):

\_\_\_\_\_

\_\_\_\_\_

Does the child/adolescent share a room with anyone else?  Yes  No

If yes, with whom? \_\_\_\_\_

If no, how long has he/she had own room? \_\_\_\_\_

Has the child/adolescent ever been placed, boarded, or lived away from the family?  Yes  No

Please explain: \_\_\_\_\_

What are the major family stresses at the present time? \_\_\_\_\_

\_\_\_\_\_

**BROTHERS and SISTERS (Please indicate if these are step-brothers/sisters or half-brothers/sisters)**

Name	Age	Sex	Living at home (yes or no)	Full/step/half sibling
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list others living in the home and their relationship to the child/adolescent:

Name	Relationship to child/adolescent
_____	_____
_____	_____

Please list the names of other people were important in this child/adolescent's life who are now deceased.

Name	Relationship to child/adolescent	Date of death
_____	_____	_____
_____	_____	_____

**HEALTH INFORMATION**

For each health concern the child/adolescent **has had** or **has now**, place a **checkmark** in the blank preceding the item. Then **note the age** of the child/adolescent when he/she experienced the health concern on the blank following the checked item.

- High fevers \_\_\_\_\_  Pneumonia \_\_\_\_\_  Flu \_\_\_\_\_  Encephalitis \_\_\_\_\_
- Meningitis \_\_\_\_\_  Convulsions \_\_\_\_\_  Unconsciousness \_\_\_\_\_  Concussions \_\_\_\_\_
- Head injury \_\_\_\_\_  Fainting \_\_\_\_\_  Dizziness \_\_\_\_\_  Tonsils out \_\_\_\_\_
- Vision Problems \_\_\_\_\_  Hearing Problems \_\_\_\_\_  Earaches \_\_\_\_\_  Dental Problems \_\_\_\_\_
- Weight Problems \_\_\_\_\_  Allergies \_\_\_\_\_  Skin Problems \_\_\_\_\_  Asthma \_\_\_\_\_
- Headaches \_\_\_\_\_  Stomach Problems \_\_\_\_\_  Accident Prone \_\_\_\_\_  Anemia \_\_\_\_\_
- Hyperactivity \_\_\_\_\_  Sinus Problems \_\_\_\_\_  Heart Problems \_\_\_\_\_
- High or low Blood Pressure \_\_\_\_\_

Has the child/adolescent ever been hospitalized?  Yes  No

If yes, please explain: \_\_\_\_\_

Has the child/adolescent ever been seen by a medical specialist?  Yes  No

If yes, please explain: \_\_\_\_\_

Please list any medications this child/adolescent has taken over the past six months including any medications he/she is taking at this time.

<u>Medication</u>	<u>Dosage</u>	<u>How often</u>	<u>Physician</u>	<u>For what reason</u>

Name of primary care physician: \_\_\_\_\_ How often does child/adolescent see this physician? \_\_\_\_\_

**HEALTH OF FAMILY MEMBERS:** Is there a history of any of the following in the family?

- |   |   |  |   |                                     |
|---|---|--|---|-------------------------------------|
| <input type="checkbox"/> tuberculosis     | <input type="checkbox"/> birth defects    | <input type="checkbox"/> thyroid problems  | <input type="checkbox"/> high blood pressure          | <input type="checkbox"/> diabetes   |
| <input type="checkbox"/> cancer           | <input type="checkbox"/> heart disease    | <input type="checkbox"/> behavior problems | <input type="checkbox"/> attention problems           | <input type="checkbox"/> depression |
| <input type="checkbox"/> bipolar disorder | <input type="checkbox"/> alcohol problems | <input type="checkbox"/> drug problems     | <input type="checkbox"/> Alzheimer's disease/dementia |                                     |

Does or did any member of the child/adolescent's family have any problems with:  reading  spelling  math  speech  
For each check, please explain: \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Prenatal: Was this child/adolescent wanted?  Yes  No      Planned for:  Yes  No

Normal pregnancy?  Yes  No

Was mother ill or upset during pregnancy?  Yes  No

If yes, please explain: \_\_\_\_\_

Did mother use any of the following during this pregnancy?

Alcohol  Yes  No      Drugs  Yes  No      Cigarettes  Yes  No

What was the father's response to this pregnancy? \_\_\_\_\_

Birth: Length of active labor: \_\_\_\_\_ hours      Full term?  Yes  No

If premature, how early: \_\_\_\_\_

If late, how late: \_\_\_\_\_

Birth weight: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

Type of delivery:  natural  cesarean  with instruments

\_\_\_\_\_ other special circumstances: \_\_\_\_\_

Physical condition of infant at birth: \_\_\_\_\_

**DEVELOPMENTAL MILESTONES**

Age at which child:

Sat up: \_\_\_\_\_

Crawled: \_\_\_\_\_

Walked: \_\_\_\_\_

Spoke single words: \_\_\_\_\_

Spoke in sentences: \_\_\_\_\_

Bladder trained: \_\_\_\_\_

Bowel trained: \_\_\_\_\_

What are your expectations/hopes for your child/adolescent? \_\_\_\_\_

**EARLY SOCIAL DEVELOPMENT**

Do you have concerns in any of these areas for your child/adolescent?

When he/she plays by him/herself:  Yes  No

If yes, please explain: \_\_\_\_\_

When he/she plays with others:  Yes  No

If yes, please explain: \_\_\_\_\_

When the objective of the play is to win (i.e. competitive play):  Yes  No

If yes, please explain: \_\_\_\_\_

When the objective of the play is to work together (i.e. cooperative play):  Yes  No

If yes, please explain: \_\_\_\_\_

How would you describe your child/adolescent's role in group play? (i.e. leader, follower, etc.) \_\_\_\_\_

List some of the strengths of this child/adolescent: \_\_\_\_\_

Describe any special habits, fears or idiosyncrasies of the child/adolescent: \_\_\_\_\_

**EDUCATIONAL HISTORY**

Name of school	City/State	Date attended from	Date attended to	Grades completed at this school
Preschool _____				
Elementary _____				
Junior High _____				
High school _____				

Types of classes: \_\_\_ regular \_\_\_ learning disability \_\_\_ EBD \_\_\_ speech therapy \_\_\_ occupational therapy \_\_\_ Day Treatment  
\_\_\_ other: \_\_\_\_\_

Does/did the child/adolescent have any specific learning problems: \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

Has the child/adolescent ever had a tutor or other special help with school work? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

What is the child/adolescent's attitude towards school? \_\_\_\_\_

Has the child/adolescent ever been suspended or expelled? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

**ACADEMIC PERFORMANCE**

Highest grade on last report card: \_\_\_\_\_ Lowest grade on last report card: \_\_\_\_\_

Favorite subject: \_\_\_\_\_ Least favorite subject: \_\_\_\_\_

Does the child/adolescent participate in extracurricular activities? (band, sports, clubs, etc.) \_\_\_ Yes \_\_\_ No

If yes, please describe: \_\_\_\_\_

In school, how many friends does the child/adolescent have? \_\_\_ lots of friends \_\_\_ a few friends \_\_\_ no friends

What are the child/adolescent's educational aspirations? \_\_\_ go to college \_\_\_ graduate from high school \_\_\_ quit school

List the child/adolescent's special interests, hobbies, skills: \_\_\_\_\_

**LEGAL HISTORY**

Has the child/adolescent ever had any difficulty with the police? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

Has the child/adolescent ever appeared in juvenile court? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

**EMPLOYMENT HISTORY**

Has the child/adolescent ever been employed? \_\_\_ Yes \_\_\_ No

Job	Employer	How long
_____	_____	_____
_____	_____	_____

