Child & Adolescent Psychiatry Consulting LLC

DBA

Behrend Psychology Consultants / **Horses Treat**

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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

___ Picks at things (nails, fingers, hair, clothing)
___ Has problems with making and keeping friends
___ Wants to run things
___ Cries easily/often
___ Has a "chip on his/her shoulder"
___ School problems (academic, behavioral, social)
___ Experiences fear and anxiety in new situations/meeting new people
___ Does not follow rules
___ Shy, does not assert self
___ Denies mistakes, is defensive
___ Steals
___ Disrespectful
___ When hurt or angered by someone, holds a grudge
___ Worries unnecessarily
___ Emotionally sensitive, easily hurt
___ Cruel and insensitive
___ Easily distracted
___ Rapid mood changes
___ Power struggles with authority
___ Does not get along well with siblings
___ Easily frustrated
___ Problems with sleep
___ Has bowel problems
___ Feels he/she is treated differently in family than siblings
___ Self-centered, brags, little understanding of others
___ Temper outbursts
___ Clumsy, problems with physical coordination
___ Undependable
___ Mean to others
___ Runs away
___ Head banging
___ Shy, timid
___ Concerns regarding sexual behavior(s)
___ Soils pants
___ Use of recreational drug(s)
___ Intense, abnormal, or illogical fears
Describe: _____
___ Strange behavior/thoughts
Describe: _____

___ Talks back to authority figures (has "an attitude")
___ Excitable, impulsive
___ Sucks or chews (thumb, clothing, blankets, etc.)
___ Emotionally reactive
___ Tendency to daydream
___ Always squirming, restless, and moving around
___ Breaks things, destructive
___ Lies, makes up stories
___ Gets into trouble more than others the same age
___ Has problems with speech (stuttering, hard to understand, baby talk)
___ Blames others for mistakes
___ Argumentative
___ Pouts and sulks
___ Develops stomachache or headache when stressed
___ Does not finish tasks
___ Bullies others
___ Clingy, in need of constant reassurance
___ Frequent headaches or stomachaches
___ Fights a lot, creates conflicts
___ Childish or immature (wants help when should be able to do it independently
___ Perfectionism interferes with trying new things
___ Problems with eating
___ Vomiting, nausea, or other complaints of pain or physical distress
___ Passive, gets pushed around
___ Irritable, cranky
___ Withdrawn, isolates self
___ Short attention span
___ Stubborn
___ Trouble with the law
___ Cuts, burns or otherwise hurts self physically
___ Rocking
___ Sets fires
___ Wets the bed
___ Alcohol use
___ Suicidal thoughts/talk

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 place 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.

Medication	Dosage	How often	Physician	For what reason

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?

___ tuberculosis ___ birth defects ___ thyroid problems ___ high blood pressure ___ diabetes
___ cancer ___ heart disease ___ behavior problems ___ attention problems ___ depression
___ bipolar disorder ___ alcohol problems ___ drug problems ___ 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	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

SUBSTANCE USE HISTORY (check all that apply for client)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used:

(complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol	_____	_____	_____	_____	___
[ ] amphetamines/speed	_____	_____	_____	_____	___
[ ] barbiturates/owners	_____	_____	_____	_____	___
[ ] caffeine	_____	_____	_____	_____	___
[ ] cocaine	_____	_____	_____	_____	___
[ ] crack cocaine	_____	_____	_____	_____	___
[ ] hallucinogens (e.g., LSD)	_____	_____	_____	_____	___
[ ] inhalants (e.g., glue, gas)	_____	_____	_____	_____	___
[ ] marijuana or hashish	_____	_____	_____	_____	___
[ ] nicotine/cigarettes	_____	_____	_____	_____	___
[ ] PCP	_____	_____	_____	_____	___
[ ] prescription_____	_____	_____	_____	_____	___
[ ] other_____	_____	_____	_____	_____	___

Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____
describe:_____

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other _____

ADDITIONAL INFORMATION

Please provide any additional information you believe might be helpful.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Sources of the data provided on this form (please check all appropriate sources below)

___ client ___ client's parent or legal guardian ___ other (please specify): _____