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Child and Adolescent BioPsychoSocial Initial Assessment

Client Information

Date: _____
Client's Name:_____
Date Of Birth _____
Gender:_____
Does the client have siblings? If so, please list names, gender, & ages._____
_____
Who does the client reside within the home:_____
_____
Who has legal custody of the client:_____
____
Is the Client adopted? _____

Presenting Symptoms **: *Describe current issues and what prompted you to seek counseling for your child:***

_____
_____
_____
_____
_____
_____

Clients previous diagnoses(if any), when diagnosed, and by who?_____
_____
_____

List name of psychiatrist, if any_____ **Length of time under his/her care**_____

List current medications prescribed by psychiatrist or other doctor for current problems:

MEDICATION	DOSAGE	FREQUENCY	START DATE	END DATE	PHYSICIAN	SIDE EFFECTS?	BENEFICIAL?

STRESSORS: ***Check any stressors below occurring at the time problems & symptoms began or since.***

_____ Family Conflict/problems
_____
_____ Family move
_____
_____Peer Conflict/problems
_____
_____ Death of friend or family
_____
_____ Problems at school
_____
_____ Medical Problems
_____
_____
_____Other
_____

When did these symptoms and issues begin? _____ What have the caregivers done to deal with them until now?_____
_____

Has the client had reported thoughts of suicide or thoughts of hurting themselves (that you are aware of) ?_____ If yes, please *describe and when these occurred :*

_____
_____
_____
_____

Describe clients school environment and grades:

_____
_____
_____

Describe clients peer (friend) group and the relationships that are occurring:

_____
_____
_____
_____
_____

Describe clients relationship(s)with family members:

_____
_____
_____

Describe the client's interests and leisure activities:

_____
_____
_____
_____

SPIRITUALITY:

Does the client believe in a Higher Power? _____ What/Who is the client's Higher Power? _____
Religious Affiliation: _____ ( )Practicing ( )Non-Practicing

_____

Do you see a need for assistance in the form of spiritual counseling to address concerns in the client's spiritual life? _____

PREVIOUS PSYCHOLOGICAL AND/OR SUBSTANCE ABUSE PROBLEMS AND TREATMENT:
List previous meds. prescribed by psychiatrist or other doctor for prior emotional problems:

MEDICATION	DOSAGE	FREQUENCY	START DATE	END DATE	PHYSICIAN	SIDE EFFECTS?	BENEFICIAL?

HOSPITALIZATIONS: (For *psychiatric or substance abuse* problems only):

DATES	FACILITY/MD/THERAPIST	PRESENTING PROBLEM	OUTCOME

THERAPY: (For *mental health or substance abuse* problems only):

DATES	THERAPIST	PRESENTING PROBLEM	OUTCOME

Check any other problems the client is experiencing difficulties with:

_____Panic Attacks
_____ Insomnia
_____ Nightmares
_____ Bedwetting
_____ Jumpy
_____ Nervous
_____ Worries a great deal
_____ Has difficulty with changes in routine
_____ Finger sucking
_____ Nail Biting
_____ Hair Pulling
_____ Restlessness
_____ Hyperactive
_____ Difficulty expressing feelings
_____ Difficult to soothe
_____ Behavioral Problems at School
_____ Aggressiveness
_____ Excessive Cursing/ Swearing
_____ Difficulty making Friends
_____ Alcohol abuse
_____ Abnormal Fears
_____ Drug abuse
_____ Behavior Problems at Home ____Impulsive behavior
_____Sadness
_____ Setting fires
___ Destruction of property
_____ Harm to animals
_____ Self Harm
_____ Binge Eating
_____ Vomiting/ Purging
_____ Anorexia
_____ Weight Loss
_____ Weight gain

____ Sexually Active
____ Gender Identity Issues
____ Sexuality Issues
____ Sexually Inappropriate Behavior
____ Addiction to Video Games
____ Addiction to Social Media
____ Addiction to Porongraphy
____ Low Self Esteem
____ Defiance
____ Running Away from Home
____ Isolating
____ Crying
____ Anger Outbursts
____ Fidgets
____ Is unable to go into a store
____ easily overstimulated
____ has difficulty focusing
____ has difficulty completing assignments or chores
____ forgetfulness
____ picky eater
____ texture issues
____ Self stimulates:(circle)rocking, head banging, twirls, repeats the same sound over and over, stimming
____ Has experienced sexual abuse
____ Has experienced verbal abuse
____ Has experienced neglect
____ Has experienced physical abuse

_____

	___

EDUCATION:

Highest grade level completed: _____
Currently attending school: YES NO Full-Time _____
IEP/ 504 in place? _____
Is Client placed in Special Education Classes? _____
School Currently Attending: _____
Current Classes and Grades in each:
_____
_____

LEGAL:

Is the client involved in any civil litigation? _____ If yes, describe:_____
_____
_____
Does the client have any criminal charges pending? _____ If yes, describe:_____
_____
_____

Is the client seeking therapy as a condition of probation, parole or as a legal condition?

Describe the client's personality :
Shy Withdrawn Outgoing Follower Leader. Introverted Extroverted Attention-seeking. Friendly Loner. Other_____

How many *close friends* does the client have? _____
Who does the client go to for emotional support? _____

Does the client have difficulty making or keeping friends:
_____

MEDICAL HISTORY:
Primary Care/Family physician: _____
Date of last physical exam:_____

MEDICAL PROBLEM	MEDICATIONS	TREATING PHYSICIAN

MAJOR SURGERIES	YEAR	MAJOR ILLNESSES	YEAR

Allergies to foods or medications:_____
FAMILY PSYCHIATRIC HISTORY OF EMOTIONAL/MENTAL PROBLEMS-Include attempted & completed suicides:

RELATIONSHIP TO client	PROBLEM(S)	TREATED (YES/NO)	CURRENT

Client Strengths: ***Describe your childs strengths:***_____
_____
_

Clients Weaknesses:Describe your child's weaknesses:
_____
_____

Hopes and Goals to for your child to Achieve from attending Therapy:
_____
_____
_____

Parent/ Guardian(s) Signature and Date

_____
_____

Angie Simonton, LCSW and Date

_____
_____

EVALUATION **DATE**

Revised 11/1/17