PSL Counseling LLC
Learn. Change. Grow.

CHILDREN / ADOLESCENETS (Age 17 and under)
SOCIAL / MEDICAL HISTORY
BIOPSYCHOSOCIAL ASSESSMENT

Please answer all questions, do not write in boxes labeled Counselor use only. Thank you.

Child's Name: _____Date: _____

Child's age: _____ Date of Birth: ____ / ____ / _____ Sex (circle one): Male Female

Address: _____
Street

_____ _____ _____
City State Zip

Phone: (Home) _____ (Cell) _____

Person filling out form: _____

Name of person responsible for bill: _____

Emergency Contact: _____ Relationship _____ Phone _____

Parents / Stepparents
Mother's name: _____ Age: _____ Education: _____ Occupation: _____

Father's name: _____ Age: _____ Education: _____ Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____ Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____ Occupation: _____

Marital status of parents: _____ If parents are separated/divorced, how old was child at time of separation? _____

With whom does the child live? _____

Custody:❑Lives in one home with both legal parents.❑Mother has physical custody.
❑Father has physical custody. ❑Physical custody is shared. ❑Other: _____

List all people living in household:
Name Age Relationship to child
_____
_____
_____
_____

If any brothers or sisters are living outside the home, list their names and ages:
_____

_____

_____ If any brothers / sisters are deceased, please give name and year: _____

FAMILY INFORMATION:
Place of birth: _____

Child's Race: ❑African-American ❑Caucasian ❑Native American ❑Hispanic ❑Asian ❑Latino ❑Other (specify)
_____

Was the child adopted? ❑Yes ❑No If yes, at what age? _____ From where? _____

Has the child ever been placed outside of the home? ❑Yes ❑No If yes, where? _____

In how many residences has the child lived since birth? _____

Has the child been physically or sexually abused, assaulted or molested? ❑Yes ❑No ❑Don't know
If yes, specify by whom and when: _____

Have the child's parents or any other family members had any mental health or emotional problems?
❑Yes ❑No If yes, describe:
_____

PRESENTING PROBLEM:
Briefly describe your child's current difficulties: _____

_____

_____

_____ How long has this problem been of concern to you?

_____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Has the child received evaluation or treatment for the current problem or similar problems? Yes ___ No ___

If yes, when and with whom?

_____ Is the child on any

medication at this time? Yes ____ No ____

If yes, please note kind of medication: _____

How do you want your child's situation to be different after coming here?
_____

For Psychologist Use Only
Presenting Problem / History of Problem:

Symptoms:

Interview / Observation of child:

SOCIAL AND BEHAVIOR CHECKLIST Place a check next to any behavior or problem that your child currently exhibits.

____ Has difficulty with speech
____ Has difficulty with hearing
____ Has difficulty with language
____ Has difficulty with vision
____ Has difficulty with coordination
____ Prefers to be alone
____ Does not get along well with other children
____ Is aggressive
____ Is shy or timid
____ Has poor bowel control (soils self)
____ Is much too active
____ Is more interested in things (objects) than in people
____ Engages in behavior that could be dangerous to self (describe)

____ Has frequent tantrums
____ Has frequent nightmares
____ Has trouble sleeping (describe) _____
____ Has blank staring spells
____ Rocks back and forth
____ Bangs head
____ Holds breath
____ Eats poorly
____ Is stubborn

_____ Describe child's relationship with his / her:

Father _____

Mother _____

Sibling(s)_____

Step parent(s) _____

OTHER INTERPERSONAL RELATIONSHIPS:
How do you describe the child's friendships:

❑No Friends ❑Only Acquaintances ❑Both acquaintances and close friends

How many close friends? _____
Place a check next to any behavior or problem that your child currently exhibits.

Check

_____ Has special fears, habits, or mannerisms (describe) _____

_____ Show daredevil behavior

_____ Gives up easily

_____ Wets bed

Check

_____ Is impulsive

_____ Sucks thumb

_____ Is slow to learn

_____ Other (describe): _____

_____

_____

EDUCATIONAL HISTORY

School: _____Grade: _____

Place a check next to any educational problem that your child currently exhibits:

Check

_____ Has difficulty with reading

_____ Has difficulty with arithmetic

_____ Has difficulty with spelling

_____ Has difficulty with writing

Check

_____ Has difficulty with other subjects (please list)

_____

_____

_____ Does not like school

Is your child in a special education class? Yes _____ No _____

If yes, what type of class? _____

Has your child been held back in a grade? Yes _____ No _____

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? Yes _____ No _____

If yes, please describe: _____

Has your child ever been suspended or expelled? Yes _____No _____

If yes, please describe: _____

DEVELOPMENTAL HISTORY During pregnancy, was mother on medication? Yes ____ No ____ If yes, what kind? _____ During pregnancy, did mother smoke? Yes ____ No ____ If yes, how many cigarettes each day? ____

During pregnancy, did mother drink alcoholic beverages? Yes ____ No ____ If yes, what did she drink? _____

Approximately how much alcohol was consumed each day? _____

During pregnancy, did mother use drugs? Yes ____ No ____ If yes, what kind? _____

Were forceps used during delivery? Yes ____ No ____

Was a Cesarean section performed? Yes ____ No ____ If yes, for what reason? _____

Was the child premature? Yes ____ No ____ If so, by how many months? _____

What was the child's birth weight? _____

Were there any birth defects or complications? Yes ____ No ____ If yes, please describe: _____
_____

Were there any feeding problems? Yes ____ No ____ If yes, please describe: _____
_____

Were there any sleeping problems? Yes ____ No ____ If yes, please describe: _____
_____

As an infant, was the child quiet? Yes ____ No ____

As an infant, did the child like to be held? Yes ____ No ____

Were there any special problems in the growth and development of the child during the first few years?
Yes ____ No ____ If yes, please describe: _____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to parent	_____	Put several words together	____
Rolled over	_____	Dressed self	____
Sat alone	_____	Became toilet trained	____
Crawled	_____	Stayed dry at night	____
Walked alone	_____	Fed self	____
Babbled	_____	Rode tricycle	____
Spoke first word	_____		

CURRENT HEALTH INFORMATION:
Describe child's health generally: ❑Good ❑Fair ❑Poor Is the child sexually active? ❑No ❑Yes

List any health problems the child has had:_____

_____

_____

Does the child have:

Current immunizations	❑No ❑Yes Which are needed? _____
Any allergies	❑No ❑Yes Specify _____
Nutritional problems	❑No ❑Yes Specify _____
Appetite problems	❑No ❑Yes Specify

_____

Sleep problems ❑No ❑Yes Specify _____

A disability or handicap ❑No ❑Yes Specify _____

Contagious or other diseases ❑No ❑Yes Specify _____

Any accidents / injuries ❑No ❑Yes Specify _____

Dental, vision or hearing problems ❑No ❑Yes Specify _____

Any hospitalizations ❑No ❑Yes Specify _____

Physician:

_____

_____ Name City

Date of last contact: ____ / ____ / ____ Reason for last contact: _____

SUBSTANCE USE / ABUSE:

Please complete the chart below

Category of Drug	Has child ever used?	Currently using?	Age at first use	How often does child use?	How taken ?	How much?	Use last 48 hours?	Withdrawal symptoms
Alcohol	❑No ❑Yes	❑No ❑Yes						
Stimulant	❑No ❑Yes	❑No ❑Yes						
Cocaine	❑No ❑Yes	❑No ❑Yes						
Tranquilizer	❑No ❑Yes	❑No ❑Yes						
Barbituate	❑No ❑Yes	❑No ❑Yes						
Marijuana	❑No ❑Yes	❑No ❑Yes						
Opiod	❑No ❑Yes	❑No ❑Yes						
Hallucinogen	❑No ❑Yes	❑No ❑Yes						
Prescribed	❑No ❑Yes	❑No ❑Yes						
Nictine	❑No ❑Yes	❑No ❑Yes						
Caffeine	❑No ❑Yes	❑No ❑Yes						
Other	❑No ❑Yes	❑No ❑Yes						

FAMILY MEDICAL HISTORY:

Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child.

Check	Condition	Relationship to child	Check	Condition	Relationship to child
____	Alcoholism	_____	____	Depression	_____
____	Cancer	_____	____	Learning disability	_____
____	Diabetes	_____	____	ADHD	_____
____	Heart trouble	_____	____	Mental Retardation	_____
____	Bipolar Disorder	_____	____	Other	_____
____	Anxiety Disorder	_____			

_

RELIGION / SPIRITUALITY:

Religion: ❑Protestant ❑Catholic ❑Buddhist ❑Hindu ❑Jewish ❑Muslim ❑Atheist ❑Agnostic ❑Other: _____

LEGAL INFORMATION:

Has the child ever:
- Had difficulty or contact with police? ❑No ❑Yes
- Appeared in juvenile conference? ❑No ❑Yes
- Been on probation? ❑Yes ❑No

Please explain: _____

_____

OTHER INFORMATION:

What are your child's favorite activities?

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

What activities would your child like to engage in more often than he/she does at present?

1. _____ 2. _____

What activities does your child like least?

1. _____ 2. _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Check	Disciplinary technique	Check	Disciplinary technique
____	Ignore problem behavior	____	Tell child to sit on chair
____	Scold child	____	Send child to his or her room
____	Spank child	____	Take away some activity or food
____	Threaten child	____	Other technique (describe) _____
____	Reason with child	____	Redirect child's interest
____	Don't use any technique		

Which disciplinary techniques are usually effective? _____

_____

With what type of problem(s)? _____

_____

Which disciplinary techniques are usually ineffective? _____

_____

With what type of problem(s)? _____

_____

What have you found to be the most satisfactory ways of helping your child? _____

_____

What are your child's assets or strengths? _____

_____

PREVIOUS COUNSELING / PSYCHOTHERAPY:

Has your child ever been in counseling / therapy before? ❑No ❑Yes

Name of Provider Clinic Year Diagnosis / Problem

_____

_____

_____

Has your child been prescribed psychotropic medication? ❑No ❑Yes

Medication: _____Dosage: _____ Prescribed by: _____

Medication: _____Dosage: _____ Prescribed by: _____

Medication: _____Dosage: _____ Prescribed by: _____

Reason:

_____

Other medications currently prescribed:

Medication: _____Dosage: _____ Prescribed by: _____

Medication: _____Dosage: _____ Prescribed by: _____

Medication: _____Dosage: _____ Prescribed by: _____

Reason: _____

Check if applicable: ❑Inpatient ❑Day Treatment ❑Substance Abuse Program
❑Psychological Testing ❑Partial Hospitalization

Explain any of the above: _____

_____

Has the child ever:

Made a suicide attempt: ❑No ❑Yes If yes, when?

_____

__

_____

Expressed homicidal thoughts: ❑Yes Describe _____
❑No _____

Had episodes of explosive anger: ❑No ❑Yes Describe _____

_____

Is the child currently expressing homicidal / suicidal feelings? ❑No ❑Yes

* * * * * * * * * * * * * * * * * * * *

Signature of Informant _____Date _____

Relationship to client _____

Signature of Counselor _____ Date _____

For Counselor Use Only

SUICIDALITY / HOMICIDALITY:

❑ Client denies any **current** suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

❑ Client reports **current** suicidal or homicidal feelings. Specify:

_____

_____

–

❑ Client denies **history** of suicidal or homicidal thoughts, feelings, gestures, intentions, or plans.

❑ Client has **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans. Specify:

_____

MENTAL STATUS:

General Behavior: cooperative, passive, withdrawn, dramatic, restless, hostile, anxious, other _____

Attire: appropriate, seductive, untidy, loud, meticulous, other _____

Gait: normal, erect, stooped, ataxic, rigid, shuffling, manneristic, other _____

Motor Activity: normal, agitated, retarded, tremor, tic, mannerism, other _____

Stream of Thought:

Productivity: spontaneous, verbose, pressured speech, unproductive, other _____

Progression: normal, loose, circumstantial, preservation, halting, blocking, incoherent, fragmented, other _____

Language: normal, baby-talk, peculiar, expression, stilted, other _____ Emotional Tone & Reactions:

Mood: normal, indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, composed,

anxious, sad, tearful, depressed, other _____ Affect: appropriate, inappropriate, other _____ Mental Trend / Content of Thoughts:

Perception: normal, auditory hallucination, visual hallucination, illusions, depersonalization, hypochondriasis, other _____

Orientation: normal, disoriented to time, place, person, other _____

Memory: normal, defective (remote, recent, immediate), other _____

General Knowledge: consistent with education, inconsistent, able to abstract, concrete, other _____ Insight: absent, good, fair, minimal Judgment: good, fair, poor DIAGNOSTIC SUMMARY:

For Counselor Use Only

Diagnostic Impressions:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V (GAF) _____

For Counselor Use Only

Goals for treatment:

1.

2.

3.

4.

Counselor's Signature_____ Date_____