Child & Adolescent Psychiatry Consulting
DBA

EMPOWER
MENTAL HEALTH CLINIC

2001 S. Central Ave, Ste A
Marshfield, WI 54449
Phone: 715-384-2818 Fax: 715-384-2724
marshfieldoffice@drjenna.net

Child/Adolescent Biopsychosocial History Form

Name of Child/Adolescent:_____ **Date:** _____

Birth date: _____ **Place of Birth:** _____**Sex:** _____**F** _____**M**

PRESENTING PROBLEMS:

Please check if the following often and/or always occurs:

____Problems with making/keeping friends
____Wants to run things
____Has a "chip on shoulder"/holds a grudge
____School problems
____Experiences fear/anxiety in new situations
____Steals
____Worries unnecessarily
____Disrespectful
____Does not follow rules
____Shy, does not assert self/is timid
____Denies mistakes/is defensive/blames others
____Cruel and insensitive
____Easily distracted
____Rapid mood changes/temper outbursts
____Power struggles with/talks back to authority
____Easily frustrated
____Problems with sleep
____Has little understanding of others
____Mean to others/bullies others
____Runs away
____Concerns regarding sexual behavior(s)
____Use of recreations drug(s)
____Strange behavior/thoughts
____Impulsive/excitable
____Emotionally reactive
____Always squirming, restless, or moving around/hyperactive
____Destructive/breaks things
____Lies/makes up stories
____Argumentative
____Pouts and sulks
____Does not finish tasks
____Clingy/in need of constant reassurance
____Frequent headaches or stomachaches
____Fights a lot/creates conflict
____Problems with eating
____Irritable/cranky
____Withdrawn/isolates self
____Suicidal thoughts/talk/self-harm
____Sets fires
____Alcohol use

Has the child/adolescent experienced any trauma: ☐Yes ☐No If yes, please briefly explain:_____

_____

Health Information:

Place a check mark for each health concern the child/adolescent has experienced.

____High Fevers
____Head Injury
____Vision Problems
____Weight Problems
____Headaches
____High or Low Blood Pressure
____Convulsions
____Fainting
____Hearing Problems
____Allergies
____Stomach Problems
____Unconsciousness
____Dizziness
____Earaches
____Skin Problems
____Accident Prone
____Heart Problems
____Concussions
____Dental Problems
____Asthma
____Anemia

Who is the Primary Care Physician?_____

Have you ever seen a mental health provider? ☐Yes ☐No

Has the Child/Adolescent ever been hospitalized? ☐Yes ☐No

Current Family Situation:

Mother's name:____

Address:____

Home Phone:____

Occupation:____

Father's name:____

Address:____

Home Phone:____

Occupation:____

Married History of Parents: ☐Married. When______________ ☐Separated. When______________ ☐Divorced. When______________

If checked yes to separation or divorced, please provide a brief description:______________________________

____

____

____

Are there parental significant others in contact with the child/adolescent? ☐No ☐ Yes. Who?__________________________

What is the custody arrangement?____

____

Was the child/adolescent adopted?_________Yes_____No

If yes, 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?______________________________

____

____

Brothers and Sisters:

Name:__________________________ **Age**:____ **Relationship:** Full Step Half **Sex:** M F **Living at Home**: Yes No

Name:__________________________ **Age**:____ **Relationship:** Full Step Half **Sex:** M F **Living at Home**: Yes No

Name:__________________________ **Age**:____ **Relationship:** Full Step Half **Sex:** M F **Living at Home**: Yes No

Name:__________________________ **Age**:____ **Relationship:** Full Step Half **Sex:** M F **Living at Home**: Yes No

Name:__________________________ **Age**:____ **Relationship:** Full Step Half **Sex:** M F **Living at Home**: Yes No

Name:__________________________ **Age**:____ **Relationship:** Full Step Half **Sex:** M F **Living at Home**: Yes No

Name:__________________________ **Age**:____ **Relationship:** Full Step Half **Sex:** M F **Living at Home**: Yes No

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

Name:____ **Relationship:**____

Name:____ **Relationship:**____

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

Name:____ **Relationship:**________________________________**Date:**__________________

Name:____ **Relationship:**________________________________**Date:**__________________

Is the child/adolescent currently taking any medication: ☐ Yes ☐ No . If yes, Please fill out:

Medication Dosage How often Prescriber Reason

Developmental History

Was the child/adolescent wanted? ☐Yes ☐ No Planned for? ☐Yes ☐No Normal pregnancy? ☐Yes ☐ No

Was the mother ill or upset during pregnancy? ☐ Yes ☐ No. If yes please explain:

Did the 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:_____Type of delivery: ☐ Natural ☐ Cesarean ☐ With instruments ☐ Other Special circumstances

Physical condition of infant at birth:

Developmental Milestones

Please check each of the following milestones the child/adolescent was late reaching:

☐Sitting up ☐Walking ☐Crawling ☐Speaking in sentences ☐Speaking single words ☐Bowel trained ☐Bladder trained

Early Social Development

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

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

When he/she plays with others: ☐ Yes ☐ No

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

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

Educational History

Current school:_____Grade:_____City/State:_____

Types of classes: ☐ Regular ☐ Learning disability ☐ EBD ☐ Speech therapy ☐ Occupational therapy

☐ Day treatment:_____ ☐ Other:_____

Does your child/adolescent have any specific learning problems: ☐ Yes ☐ No. If yes, please explain:

Does the child/adolescent have: ☐ IEP plan ☐ 504 plan ☐ Special education plan

Has the child/adolescent ever had a tutor or other special help with school work? Yes No. If yes, please explain:

In school, how many friends does the child/adolescent have? ☐ Lots of friends ☐ A few friends ☐ No friends

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

List some of the strengths of this child/adolescent:

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

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

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 ☐ Client's legal guardian ☐ Other (specify):

Signature: Date: