

CHILD AND ADOLESCENT BIOPSYCHOSOCIAL QUESTIONNAIRE

Please bring this completed form with you at the time of your first appointment.

Thank you for your investment of time. This information will help us to give the best care possible.

Date you completed this form: _____

Person who completed this form: _____

Relationship to child: _____

It is preferable that both parents accompany the child to the first consultation, if possible.

Child's name _____ Birthdate _____ Age _____ Sex _____
last first middle

Home address _____
street city state zip

Home telephone number _____

Emergency Contact _____ Telephone _____

Child's school _____ Telephone _____
Name

Grade _____
Address

Child's living situation (place check in appropriate box):

	<u>Column A</u> Adults with whom child is living	<u>Column B</u> Non-residential adults involved with child
Natural mother	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Natural father	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Stepmother	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Stepfather	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Adoptive mother	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Adoptive father	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Foster mother	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Foster father	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Other (specify)	_____	_____

Place the number 1 next to the child's primary residential caregiver (Column A above) and provide the following information:

1. Name _____ Occupation _____

Business name _____ Business phone # _____

Business Address _____

Client Name _____

Place the number 2 next to the child's secondary residential caregiver (Column A above) and provide the following information:

2. Name _____ Occupation _____
Business name _____ Business phone # _____
Business Address _____

Place the number 3 next to the person checked in Column B who is most involved with the child and provide the following information:

3. Name _____ Home phone # _____
Home address _____
Occupation _____ Business name _____
Business address _____ Business phone no. _____

If primary caregivers work outside the home, who cares for the child when caregivers are away?

How many hours per week is this child in this child-care setting: _____

If child was adopted, how old when s/he was adopted? _____

If child is or was in foster care, describe number and quality of placements, along with length of time in each (please, use separate sheet of paper and attach).

Who referred you to _____ ? Name _____

Address _____

_____ Phone no. _____

Pediatrician or family doctor _____

Address _____

Phone # _____ Date of last appointment _____

Reason for appointment _____

Why are you seeking counseling for this child now? (brief summary of the main problems, please include when the problems began and how long each lasted):

Client Name _____

PREGNANCY

Duration of pregnancy _____ weeks

Complications:

☐ Excessive vomiting ☐ Hospitalization required

☐ Excessive staining or blood loss ☐ Threatened miscarriage

Infection(s) (specify) _____

☐ Toxemia ☐ Operation(s) (specify) _____

Other illness(es) (specify) _____

☐ Smoking during pregnancy Average number of cigarettes per day _____

☐ Alcohol consumption during pregnancy

Describe what and how often _____

☐ Drugs taken during pregnancy (please specify if prescriptions) _____

☐ X-ray studies during pregnancy _____

DELIVERY

Mother's age at birth: _____

Father's age at birth: _____

Type of labor: ☐ Spontaneous ☐ Induced _____ Forceps: ☐ high ☐ mid ☐ low

Duration of labor: _____ hours

Caesarean delivery ☐ Yes ☐ No

Complications:

☐ Cord around neck ☐ Cord presented first ☐ Hemorrhage ☐ Infant injured during delivery

Other (specify) _____

Birth weight _____

☐ Appropriate for gestational age (AGA) ☐ Small for gestational age (SGA)

Mother's condition at birth _____

Child's condition at birth _____

POST-DELIVERY PERIOD (while in the hospital)

Respiration: ☐ immediate ☐ delayed (if so, how long) _____

Cry: ☐ immediate ☐ delayed (if so, how long) _____

☐ Mucus accumulation ☐ Apgar score (if known) _____ ☐ Jaundice

Rh factor _____ ☐ transfusion ☐ Cyanosis (turned blue)

☐ Incubator care Number of days _____ Oxygen given? _____ How long? _____

Suck: ☐ strong ☐ weak

Infection (specify) _____

☐ Vomiting ☐ Diarrhea

Client Name _____

Birth defects (specify) _____

Total number of days baby was in the hospital after the delivery _____

INFANCY-TODDLER PERIOD

Were any of the following present to a significant degree during the first few years of life? If so, describe.

- ☐ Did not enjoy cuddling
- ☐ Was not calmed by being held and/or stroked
- ☐ Colic
- ☐ Excessive restlessness
- ☐ Diminished sleep because of restlessness and easy arousal
- ☐ Frequent headbanging
- ☐ Constantly into everything
- ☐ Excessive number of accidents compared to other children

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, check item at right.

	I cannot recall exactly, but to the best of my recollection it occurred		
	Age	<u>early</u>	<u>at the normal time</u> <u>late</u>
Smiled			
Sat without support			
Crawled			
Stood without support			
Walked without assistance			
Spoke first words besides "ma-ma" and "da-da"			
Said phrases			
Said sentences			
Bowel trained, day			
Bowel trained, night			
Bladder trained, day			
Bladder trained, night			
Rode tricycle			
Rode bicycle (without training wheels)			
Buttoned clothing			
Tied shoelaces			
Named colors			
Named coins			
Said alphabet in order			
Began to read			

COORDINATION

Rate your child on the following skills:

	<u>Good</u>	<u>Average</u>	<u>Poor</u>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throwing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoelace tying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buttoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athletic abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Client Name _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? _____ If not, why not? _____

How would you rate your child's overall level of intelligence compared to other children?
☐ below average ☐ average ☐ above average

SCHOOL

Rate your child's school experiences related to academic learning.

	<u>Good</u>	<u>Average</u>	<u>Poor</u>
Nursery school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kindergarten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To the best of your knowledge, at what grade level is your child functioning:
Reading _____ Spelling _____ Arithmetic _____

Has your child ever had to repeat a grade? If so, when? _____

Present class placement: ☐ regular class ☐ special class (if so, specify) _____

Kinds of special therapy or remedial work your child is currently receiving at school:

Describe briefly any academic school problems _____

Do you have concerns about the quality of your child's school or teacher? _____

Rate your child's school experience related to behavior:

	<u>Good</u>	<u>Average</u>	<u>Poor</u>
Nursery school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kindergarten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does your child's teacher describe any of the following as significant classroom problems?

- ☐ Doesn't sit still in his or her seat
- ☐ Frequently gets up and walks around the classroom
- ☐ Shouts out. Doesn't wait to be called upon.
- ☐ Won't wait his or her turn.
- ☐ Does not cooperate well in group activities
- ☐ Typically does better in a one-to-one relationship
- ☐ Doesn't respect the rights of others
- ☐ Doesn't pay attention during storytelling

Describe briefly any other classroom behavioral problems _____

PEER RELATIONSHIPS

- ☐ My child seeks friendships with peers.
- ☐ My child is sought by peers for friendship.
- ☐ My child plays primarily with children his or her own age.
- ☐ My child plays primarily with younger children.
- ☐ My child plays primarily with older children.

Describe briefly any problems your child may have with peers. _____

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

- ☐ Hyperactivity (high activity level)
- ☐ Poor attention span
- ☐ Impulsivity (poor self-control)
- ☐ Low frustration tolerance
- ☐ Temper outbursts
- ☐ Sloppy table manners
- ☐ Interrupts frequently
- ☐ Doesn't listen when being spoken to
- ☐ Sudden outbursts of physical abuse of other children
- ☐ Acts like he or she is driven by a motor
- ☐ Wears out shoes more frequently than siblings
- ☐ Heedless to danger
- ☐ Excessive number of accidents
- ☐ Doesn't learn from experience
- ☐ Poor memory
- ☐ More active than siblings or peers

Most children exhibit, at one time or another, one or more of the symptoms listed below. Place a P next to those that your child has exhibited in the PAST and an N next to those that your child exhibits NOW. Only mark those symptoms that have been or are present to a significant degree over a period of time. Only check as problems behavior that you suspect is unusual or atypical when compared to what you consider to be the normal for your child's age. Then, on pages 8-9, list the symptoms checked off on pages 6-8 and write a brief description including age or onset, duration, and any other pertinent information.

- | | | |
|---|--|--|
| _____ Thumb sucking | _____ Generally immature | _____ Preoccupied with food—
what to eat and what not
to eat |
| _____ Baby talk | _____ Eats non-edible
substances | _____ Preoccupation with
bowel movements |
| _____ Overly dependent for
age | _____ Overeating with
overweight | _____ Constipation |
| _____ Frequent temper
tantrums | _____ Eating binges with
overweight | _____ Encopresis (soiling) |
| _____ Excessive silliness and
clowning | _____ Undereating with
overweight | _____ Insomnia (difficulty
sleeping) |
| _____ Excessive demands for
attention | _____ Long periods of dieting
and food abstinence with
underweight | _____ Enuresis (bed wetting) |
| _____ Cries easily and
frequently | | _____ Frequent nightmares |

Client Name _____

<input type="checkbox"/> Night terrors (terrifying night-time outbursts)	<input type="checkbox"/> Destruction of property	<input type="checkbox"/> Bribes other children
<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Criminal and/or dangerous acts	<input type="checkbox"/> Excessively competitive
<input type="checkbox"/> Excessive sexual interest and preoccupation	<input type="checkbox"/> Trouble with the police	<input type="checkbox"/> Often cheats when playing games
<input type="checkbox"/> Frequent sex play with other children	<input type="checkbox"/> Violent assault	<input type="checkbox"/> "Sore loser"
<input type="checkbox"/> Excessive masturbation	<input type="checkbox"/> Fire setting	<input type="checkbox"/> "Doesn't know when to stop"
<input type="checkbox"/> Frequently likes to wear clothing of the opposite sex	<input type="checkbox"/> Little, if any, guilt over behavior that causes others pain and discomfort	<input type="checkbox"/> Poor common sense in social situations
<input type="checkbox"/> Exhibits gestures and intonations of the opposite sex	<input type="checkbox"/> Little, if any, response to punishment for anti-social behavior	<input type="checkbox"/> Often feels cheated or treated unfairly
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Few, if any, friends	<input type="checkbox"/> Feels others are persecuting him/her when there is no evidence for such
<input type="checkbox"/> Frequent stomach cramps	<input type="checkbox"/> Doesn't seek friendships	<input type="checkbox"/> Typically wants her or his own way
<input type="checkbox"/> Frequent nausea and vomiting	<input type="checkbox"/> Rarely sought by peers	<input type="checkbox"/> Very stubborn
<input type="checkbox"/> Often complains of bodily aches and pains	<input type="checkbox"/> Not accepted by peer group	<input type="checkbox"/> Obstructionistic
<input type="checkbox"/> Worries over bodily illness	<input type="checkbox"/> Selfish	<input type="checkbox"/> Negativistic (does just the opposite of what is requested)
<input type="checkbox"/> Poor motivation	<input type="checkbox"/> Doesn't respect the rights of others	<input type="checkbox"/> Quietly or silently defiant of authority
<input type="checkbox"/> Apathy	<input type="checkbox"/> Wants things own way with exaggerated reaction if thwarted	<input type="checkbox"/> Feigns or verbalizes compliance or cooperation but doesn't comply with requests
<input type="checkbox"/> Takes path of least resistance	<input type="checkbox"/> Trouble putting self in other person's position	<input type="checkbox"/> Drug use
<input type="checkbox"/> Tries to avoid responsibility	<input type="checkbox"/> Egocentric (self-centered)	<input type="checkbox"/> Alcohol use
<input type="checkbox"/> Poor follow-through	<input type="checkbox"/> Frequently hits other children	<input type="checkbox"/> Very tense
<input type="checkbox"/> Low curiosity	<input type="checkbox"/> Argumentative	<input type="checkbox"/> Nail biting
<input type="checkbox"/> Open defiance of authority	<input type="checkbox"/> Excessively critical of others	<input type="checkbox"/> Chews on clothes, blankets, etc.
<input type="checkbox"/> Blatantly uncooperative	<input type="checkbox"/> Excessively taunts other children	<input type="checkbox"/> Head banging
<input type="checkbox"/> Persistent lying	<input type="checkbox"/> Complains often	<input type="checkbox"/> Hair pulling
<input type="checkbox"/> Frequent use of profanity to parents, teachers, and other authorities	<input type="checkbox"/> Is often picked on and easily bullied by other children	<input type="checkbox"/> Picks on skin
<input type="checkbox"/> Truancy from school	<input type="checkbox"/> Suspicious, distrustful	<input type="checkbox"/> Speaks rapidly and under pressure
<input type="checkbox"/> Runs away from home	<input type="checkbox"/> Aloof	<input type="checkbox"/> Irritable, easily "flies off the handle"
<input type="checkbox"/> Violent outbursts of rage	<input type="checkbox"/> "Wise-guy" or smart aleck attitude	<input type="checkbox"/> Anxiety attacks with palpitations (heart pounding), shortness of breath, sweating, etc.
<input type="checkbox"/> Stealing	<input type="checkbox"/> Brags or boasts	
<input type="checkbox"/> Cruelty to animals, children, or others		

FEARS

<input type="checkbox"/> dark	<input type="checkbox"/> Often appears insincere and/or artificial	<input type="checkbox"/> Compulsive repetition of seemingly meaningless physical acts
<input type="checkbox"/> new situations	<input type="checkbox"/> Too mature, frequently acts older than actual age	<input type="checkbox"/> Shy
<input type="checkbox"/> strangers	<input type="checkbox"/> Excessive guilt over minor indiscretions	<input type="checkbox"/> Inhibited self-expression in dancing, singing, laughing, etc.
<input type="checkbox"/> being alone	<input type="checkbox"/> Asks to be punished	<input type="checkbox"/> Recoils from affectionate physical contact
<input type="checkbox"/> death	<input type="checkbox"/> Low self-esteem	<input type="checkbox"/> Withdrawn
<input type="checkbox"/> separation from parent	<input type="checkbox"/> Excessive self-criticism	<input type="checkbox"/> Fears asserting self
<input type="checkbox"/> school	<input type="checkbox"/> Very poor tolerance of criticism	<input type="checkbox"/> Inhibits open expression of anger
<input type="checkbox"/> visiting other children's homes	<input type="checkbox"/> Feelings easily hurt	<input type="checkbox"/> Allows self to be easily taken advantage of
<input type="checkbox"/> going away to camp	<input type="checkbox"/> Dissatisfaction with appearance or body part(s)	<input type="checkbox"/> Frequently pouts and/or sulks
<input type="checkbox"/> animals	<input type="checkbox"/> Excessive modesty over bodily exposure	<input type="checkbox"/> Mute (refuses to speak) but can
<input type="checkbox"/> other fears (name) _____	<input type="checkbox"/> Perfectionistic, rarely satisfied with performance	<input type="checkbox"/> Gullible and/or naïve
<input type="checkbox"/> Disorganized	<input type="checkbox"/> Frequently blames others as a cover-up for own shortcomings	<input type="checkbox"/> Passive and easily led
<input type="checkbox"/> Tics such as eye-blinking, grimacing, or other spasmodic repetitious movements	<input type="checkbox"/> Little concern for personal appearance or hygiene	<input type="checkbox"/> Excessive fantasizing, "lives in her/his own world"
<input type="checkbox"/> Involuntary grunts, vocalizations (understandable or not)	<input type="checkbox"/> Little concern for or pride in personal property	<input type="checkbox"/> Flat emotional tone
<input type="checkbox"/> Stuttering	<input type="checkbox"/> "Gets hooked" on certain ideas and remains preoccupied	<input type="checkbox"/> Speech noncommunicative or poorly communicative
<input type="checkbox"/> Depression		<input type="checkbox"/> Hears voices
<input type="checkbox"/> Frequent crying spells		<input type="checkbox"/> Sees visions
<input type="checkbox"/> Excessive worrying over minor things		
<input type="checkbox"/> Suicidal preoccupation, gestures, or attempts		
<input type="checkbox"/> Excessive desire to please authority		
<input type="checkbox"/> "Too good"		

As requested, please first list below symptoms from list above marked with the letter P (for past) and next to each symptom give descriptive information such as when symptom began, how long it lasted, and other important data. Then list symptoms marked with an N (for now) and provide similar information.

P or N	Symptom	Brief Description
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____

Client Name _____

P or N

Symptom

Brief Description

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY SPIRITUAL HISTORY

Attend church? ☐ Yes ☐ No

If yes, denomination _____

Level of involvement of parents _____

Level of involvement of child _____

Attitude of client toward God _____

Attitude of client toward church _____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____

What are your child's areas of greatest accomplishment? _____

What does your child enjoy doing most? _____

What does your child dislike doing most? _____

What are your child's greatest strengths? _____

What are your child's weaknesses? _____

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications) _____

Client Name _____

Operations _____

Hospitalizations for illness(es) other than operations _____

Head injuries _____ with unconsciousness _____ without unconsciousness

Convulsions _____ with fever _____ without fever

Coma _____

Meningitis or encephalitis _____

Immunization reactions _____

Persistent high fevers _____ Highest temperature ever recorded _____

Eye problems _____

Ear problems _____

Poisoning _____

PRESENT MEDICAL STATUS

Present height _____ Present weight _____

Present illness(es) for which child is being treated _____

Medications child is taking on an ongoing basis _____

Allergies to medication: _____

Allergies to food: _____

Other allergies: _____

FAMILY HISTORY—MOTHER

Age _____ Age at time of pregnancy with client _____

Number of previous pregnancies _____ Number of spontaneous abortions (miscarriages) _____

Number of induced abortions _____

Fertility problems (specify) _____

School: Highest grade completed _____

Learning problems (specify) _____ grade repeat _____

Behavior problems (specify) _____

Medical problems (specify) _____

Client Name _____

Have you or any of your blood relatives (not including client and siblings) ever had problems similar to those your child has? If so, describe. _____

FAMILY HISTORY—FATHER

Age _____ Age at time of client's conception _____

Fertility problems (specify) _____

School: Highest grade completed _____

Learning problems (specify) _____ grade repeat _____

Behavior problems (specify) _____

Medical problems (specify) _____

Have you or any of your blood relatives (not including client and siblings) ever had problems similar to those your child has? If so, describe. _____

SIBLINGS

	<u>Name</u>	<u>Age</u>	<u>Medical, social, or academic problem</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

FAMILY EMOTIONAL/PSYCHOLOGICAL HISTORY (Include extended family members, such as aunts, uncles, cousins, grandparents, etc.):

Has the child had previous outpatient psychotherapy? ☐ Yes ☐ No

If yes, by whom and for how long? _____

Name

Telephone

Address

Length and frequency of treatment: _____

What was the diagnosis and outcome? _____

Has any family member had outpatient psychotherapy? ☐ Yes ☐ No

If yes, what is relationship to child and why did this person seek treatment? (list all):

Has the child had previous inpatient treatment? ☐ Yes ☐ No

If yes, how many times? _____ How long was the longest stay? _____

Name of facility

Telephone

Address

Client Name _____

What was the diagnosis and outcome? _____

Has any family member had inpatient treatment for psychological, emotional, or substance abuse problem? ☐ Yes ☐ No

If yes, what is their relationship to the child and why did they seek treatment? _____

Do any family members take medications for psychological problems? ☐ Yes ☐ No

If yes, what is their relationship to the child and what problem does the medicine treat? (list all):

Please describe what current stress the family is experiencing:

Inadequate housing? _____

Financial problems? _____

Divorce? _____

Recent death in family? _____

Other: _____

Do you think any of the above will interfere with treatment? _____

LIST NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ANY OTHER PROFESSIONALS CONSULTED (e.g., neurologists, speech therapists, etc.):

1. _____

2. _____

3. _____

4. _____

ADDITIONAL REMARKS

Please use the remainder of this page to write any additional comments you wish to make regarding your child's difficulties.