CHILD/ADOLESCENT BIOPSYCHOSOCIAL QUESTIONNAIRE

Name of Child/Adolescent: ___________________________ DOB: _______ Gender: _______
Address: ____________________________________________ Phone: ________________
Name of Person completing this Questionnaire: ___________________________ Date: __________
Reason for referral: ________________________________________________

PRESENTING PROBLEMS

Please check all that apply:

_____ Very Unhappy  _____ Impulsive  _____ Fire Setting
_____ Irritable  _____ Stubborn  _____ Stealing
_____ Temper Outbursts  _____ Disobedient  _____ Lying
_____ Withdrawn  _____ Infantile  _____ Sexual Trouble
_____ Daydreaming  _____ Mean To Others  _____ School Performance
_____ Fearful  _____ Destructive  _____ Truancy
_____ Clumsy  _____ Trouble With Law  _____ Bed Wetting
_____ Overactive  _____ Running Away  _____ Soiled Pants
_____ Slow  _____ Self Mutilating  _____ Eating Problems
_____ Short Attention Span  _____ Head Banging  _____ Sleeping Problems
_____ Distractible  _____ Rocking  _____ Sickly
_____ Lacks initiative  _____ Shy  _____ Drug Use
_____ Undependable  _____ Strange behavior  _____ Alcohol Use
_____ Peer Conflict  _____ Strange thoughts  _____ Suicide Talk
_____ Sadness  _____ Obsessions or Compulsive Acts  _____ Anxiety
_____ Fearfulness  _____ Phobias  _____ Other
_____ Communication Problems  _____ Socialization Problems  _____ Unusual Motor Behavior

Please explain:
How long have these problems occurred?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What happened that makes you see help at this time?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Problems perceived to be:  _____very serious  _____serious  _____not serious

What are your child’s strengths?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What are your strengths as a family?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What are your expectations of your child?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What changes would you like to see in your child?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What changes would you like to see in yourself?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What changes would you like to see in your family as a whole?

____________________________________________________________________________________
____________________________________________________________________________________
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**BIRTH FAMILY INFORMATION**

<table>
<thead>
<tr>
<th>MOTHER</th>
<th>FATHER</th>
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<tr>
<td>Name:</td>
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<tr>
<td>Race:</td>
<td>Race:</td>
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<tr>
<td>D.O.B.</td>
<td>D.O.B.</td>
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<tr>
<td>AGE:</td>
<td>AGE:</td>
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<tr>
<td>S.S. #</td>
<td>S.S.#</td>
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<tr>
<td>Religion Affiliation:</td>
<td>Religious Affiliation:</td>
</tr>
<tr>
<td>Marital Status:</td>
<td>Marital Status:</td>
</tr>
<tr>
<td>Level of Education:</td>
<td>Level of Education:</td>
</tr>
<tr>
<td>Currently Employed: Yes_____No______</td>
<td>Currently Employed: Yes_____No______</td>
</tr>
<tr>
<td>Occupation:</td>
<td>Occupation:</td>
</tr>
<tr>
<td>Place of Employment:</td>
<td>Place of Employment:</td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Work Phone:</td>
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</tbody>
</table>

If not married (or residing in the same household) which parent is the primary caretaker? -

Parental rights terminated?_________YES______________NO

1. If Yes, date of termination? _______________________
2. If Yes, who is the primary resource for the child? _________________
3. If Yes, is child freed for adoption? ___________YES ______________NO

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<thead>
<tr>
<th>SIBLINGS</th>
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<tbody>
<tr>
<td>NAME</td>
<td>DOB</td>
<td>AGE</td>
<td>SEX</td>
<td>FULL/HALF</td>
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</table>

Significant Others: (relatives living in the home, grandparents, or any person having regular involvement with the child):

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP TO CHILD</th>
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</table>

**Financial:** What is the nature of the family’s financial situation, primary source of income?

__________________________________________________________

**Spiritual:** What is the significance/influence of the family’s religious beliefs (is the family actively involved in church activities, are there any conditions/ restrictions based upon religious beliefs that should be noted):

__________________________________________________________

**Cultural:** Are there any other cultural factors in terms of the family’s beliefs, values, environmental influences, or ethnicity that should be considered in planning for the child and family?

__________________________________________________________
DRUG, ALCOHOL AND TOBACCO ASSESSMENT

Has your child used any type of mood altering substance (cigarettes, alcohol, marijuana, cocaine, pills, huffing fumes…)

____ Yes   ___ No   ____ Not to my knowledge   _____ Maybe, Not Sure

If yes, what type of substance is used, how much, and how often

______________________________________________________________________________

______________________________________________________________________________

In your direct family, has anyone had problems (e.g. reprimanded at work, fired, increased arguments at home, domestic violence) due to substance use?

____ Yes   ___ No

If yes, who has the problem, what problems have surfaced (fired, domestic violence…) and what is their drug of choice: ________________________________

______________________________________________________________________________

______________________________________________________________________________

Is there a history of drug or alcohol problems in the extended family? ___ Yes ___ No

If yes, please list the name and relationship the family member(s) has to your child, the types of substances abused, and the family problems it caused:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

ABUSE HISTORY

In your family, has anyone been physically abused in their lifetime? ________________________________

If yes, who was physically abused, and who did the abusing? ________________________________

______________________________________________________________________________

______________________________________________________________________________

In your family, has anyone been sexually abused in their lifetime? ________________________________

If yes, who was sexually abused, and who did the abusing? ________________________________

______________________________________________________________________________

______________________________________________________________________________

In your family, has anyone been emotionally/mentally abused in their lifetime? ________________________________

If yes, who was emotionally/mentally abused, and who did the abusing? ________________________________

______________________________________________________________________________

______________________________________________________________________________
### DEVELOPMENTAL HISTORY

<table>
<thead>
<tr>
<th>At birth, age of:</th>
<th>Mother:</th>
<th>Father:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning Sickness</td>
<td>None ☐</td>
<td>For 3 months ☐</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>German measles</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Swelling of legs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other infections</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Convulsions</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Accidents</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Required Special Medical Care during pregnancy</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Total number of pregnancies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other/special problems:</td>
<td></td>
<td></td>
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</tbody>
</table>

Please specify details (i.e., month of pregnancy, type of treatment received, and how long condition lasted) regarding any item checked above.

### BIRTH HISTORY:

<table>
<thead>
<tr>
<th>Length of pregnancy/ # weeks:</th>
<th>Was anesthesia used at delivery?</th>
<th>What kind?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overdue</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Length of labor</td>
<td>Described as easy</td>
<td>☐</td>
</tr>
<tr>
<td>Difficult</td>
<td>Birth was spontaneous</td>
<td>☐</td>
</tr>
<tr>
<td>Required forceps</td>
<td>Caesarean</td>
<td>☐</td>
</tr>
<tr>
<td>Infant was born head first</td>
<td>Breech/specify</td>
<td>☐</td>
</tr>
<tr>
<td>Birth weight of infant</td>
<td>Birth length</td>
<td>☐</td>
</tr>
<tr>
<td>Was he/she yellow?</td>
<td>☐ Yes ☐ No Infant required oxygen</td>
<td>☐</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>Other medical attention</td>
<td>☐</td>
</tr>
<tr>
<td>Infant had difficulty breathing</td>
<td>Vomited</td>
<td>☐</td>
</tr>
<tr>
<td>Was irritable</td>
<td>☐ Was mother and infant discharged from hospital together?</td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>If not, when did infant leave hospital:</td>
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### ADDITIONAL INFORMATION/COMMENTS:

Was mother the main caretaker of the baby? ☐ Yes ☐ No

Infant was breast fed ☐ Until age: Bottle fed ☐ Until age:

How did child except weaning? (Cried, began sucking thumb, fussed, etc.)

Problems with:

☐ vomiting ☐ diarrhea ☐ constipation

☐ colic ☐ allergies ☐ rashes

Please give details regarding any of the above or other problems:

Was child:

☐ restless ☐ happy ☐ “good” baby ☐ “fussy” baby ☐ other

When did you add solid foods? ☐ Was there a normal weight gain?

Have there been any serious feeding disturbances during youngster’s developing? ☐ Yes ☐ No

If yes, describe and specify age(s):

Were foods omitted from diet? ☐ Yes ☐ No ☐ If yes what and why?

At what age did child first:

Develop teeth ☐ First sit up ☐ First crawl

Walk alone ☐ Say first words ☐ Begin to speak in sentences

Any problems: ☐ Yes ☐ No ☐ If yes, please specify

At what age did toilet training begin? ☐ Bowel? ☐ When complete?

Bladder? ☐ When complete? ☐ Any difficulties in training?
### PHYSICAL HEALTH HISTORY

#### HOSPITALIZATION OR SURGERY

<table>
<thead>
<tr>
<th>DATE</th>
<th>REASON</th>
<th>DATE</th>
<th>REASON</th>
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<table>
<thead>
<tr>
<th>DRUG ALLERGIES</th>
<th>CURRENT MEDICATIONS</th>
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#### MEDICAL HISTORY

- abdominal pain – chronic
- allergies/hayfever
- anemia □ bruise easily
- ankles – swollen
- appetite – loss of
- arthritis/rheumatism
- asthma/wheezing
- back pain – recurrent
- bone fracture/joint injury
- bowel habits – change in
- bronchitis/chronic cough
- cancer
- chest pain
- convulsions/seizures
- diabetes
- diarrhea □ constipation
- diverticulosis □ crohn’s colitis
- nausea/vomiting – persistent
- nervousness □ depression
- venereal disease
- fatigue – chronic
- foot pain □ cold numb feet
- gall bladder trouble
- gout
- hair loss
- headaches – frequent
- heart murmur/defects
- hemmorhoids
- hemia
- high blood pressure
- indigestion or heartburn
- infections – frequent
- jaundice/hepatitis
- kidney stones
- lactose intolerance
- leg pain – walking
- memory loss
- mental illness
- muscle weakness
- urine – blood in
- varicose veins/phlebitis
- eye infections
- osteoporosis
- pneumonia
- prostate disease
- psoriasis □ eczema
- rashes □ hives
- sexual/menstrual dysfunction
- sinus trouble
- stools – bloody or tarry
- stroke
- swallowing difficulty
- tetanus
- throat – sore – frequent
- thyroid disease
- tremor/hands shaking
- ulcers – peptic
- urethral discharge
- diphtheria
- dizziness/fainting
- ear infections – frequent
- ear – ringing in
- numbness/tingling sensations
- weight loss – recent
- chicken pox
- polio □ mumps
- measles
- rubella
- rheumatic fever
- scarlet fever
- tuberculosis
- herpes
- Urination - □ overnight – less than twice
- bed wetting
- □ painful □ loss of control
- □Sickle Cell Disease/Trait
- □Heart Disease
- □Bone fractures
- □ Other ________________________________

#### FAMILY MEDICAL HISTORY

- Alcoholism
- Asthma
- Bleeding disorder
- Cancer
- Diabetes
- Epilepsy/convulsions
- Glaucoma
- Hair loss
- Heart disease
- High blood pressure
- Kidney disease
- Mental illness
- Migraine
- Osteoporosis
- Stroke
- Thyroid disease

#### HABITS

- □ Alcohol: Type ________________________________
  Amount: ________________________________
- □ Coffee: cups daily
  Other caffeine: ________________________________
- □ Diet: Salt intake
  Fat intake: ________________________________
  Other: ________________________________
- □ Exercise Routine: ________________________________
- □ Sleep: Difficulty falling asleep:
  Continuity Disturbances ________________________________
  Early Morning Awakening ________________________________
  Daytime Drowsiness ________________________________
  Other: ________________________________
- □ Smoke: Packs daily ________________________________
  How long
  Interested in stopping? ________________________________
EDUCATION HISTORY

School Placement History

<table>
<thead>
<tr>
<th>School</th>
<th>Dates or Grades</th>
<th>Placement Type</th>
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Has your child repeated any grades? If yes, explain:

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Most recent Achievement Test:

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<thead>
<tr>
<th>Type</th>
<th>Date</th>
<th>Results</th>
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What are your child's academic/school strengths (i.e.: favorite subjects, involvement in school activities, helpful, attentive, obeys rules, etc.):  

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Has your child ever been recommended for special classes? If yes, explain:  

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Does your child currently have or ever had an IEP? If yes, explain:  

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</table>

LEISURE AND RECREATION

What are some examples of how child likes to spend his/her time, any special interests:

Check all that apply to child:

___Watches TV frequently    ___ Need to learn to relax    ___Believes he/she is clumsy
___Likes to read            ___ Seldom interactive      ___Enjoys painting/drawing
___Enjoys playing games     ___ Enjoys machines       ___Enjoys woodworking
___Likes hiking/being outside___Enjoys computers     ___Likes to create or build
___Enjoys watching sports (which ones?)   ___Enjoys playing sports (which ones?)   ___Spends much time on Internet

Other: ____________________________

Does child have a best friend?   _______Yes _______No

Name of best friend ____________

Age of best friend ____________ How often does child see best friend ______________________

Does child have a steady girlfriend/boyfriend?   _______Yes _______No

Does child date on a regular basis?   _______Yes _______No

Is child sexually active?   _______Yes _______No

Has child ever been, or currently employed?   _______Yes _______No

If yes, what type of job, length of employment, number of hours worked per week:

_____________________________________________________________________________________
____________________________________________________________________________________
PAST MENTAL HEALTH TREATMENT

Has anyone in your family ever received past/current mental health treatment? ______________

If yes: Who received treatment, when did they receive it and what type of treatment did they receive? ______________

____________________________________________________________________

____________________________________________________________________

Has the child ever received past/current mental health treatment? ______________

If yes: When did they receive it and what type of treatment did they receive? ______________

Inpatient: ______________
Outpatient: ______________
Medication: ______________
Family Based: ______________
BHRS (Wrap Around Services): ______________
Other: ______________

Explain further if needed:

____________________________________________________________________

____________________________________________________________________

Effectiveness of past treatment:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

______________________________    _________________________
Signature of Parent/Legal Guardian                                                   Date

______________________________________________________    ____________________
Consumer Signature (if 14 years of age or older)                              Date

______________________________    _________________________
Robert A. Lowenstein MD                                                   Date