ROBERT A. LOWENSTEIN MD PC

Community Psychiatric Centers

Psychiatric Services for Children, Teens, and Adults

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?

BIRTH FAMILY INFORMATION

MOTHER	FATHER
Name:	Name:
Race:	Race:
D.O.B. AGE:	D.O.B. AGE:
S.S. #	S.S.#
Religion Affiliation:	Religious Affiliation:
Marital Status:	Marital Status:
Level of Education:	Level of Education:
Currently Employed: Yes_____No_____	Currently Employed: Yes_____No_____
Occupation:	Occupation:
Place of Employment:	Place of Employment:
Work Phone:	Work Phone:

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

SIBLINGS

NAME	DOB AGE	SEX	FULL/HALF	RESIDENCE

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

NAME	RELATIONSHIP TO CHILD

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):

*Cultura*l: 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

At birth, age of:		Mother:		Father:	
Morning Sickness	None ☐	For 3 months ☐	Or longer ☐	Bleeding ☐	Diabetes ☐

Kidney disease	☐	Unusual emotional strain or worries	☐
German measles	☐	Unusual physical factors	☐
High blood pressure	☐	Mother felt life during pregnancy	☐
Swelling of legs	☐	Confined to bed	☐
Other infections	☐	How long:	
Convulsions	☐	Mother smoked during pregnancy	☐
Accidents	☐	Drug/alcohol consumption	☐
Required Special Medical Care during pregnancy			☐
Total number of pregnancies:			
Other/special problems:			

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

_____

_____

_____

BIRTH HISTORY:

Length of pregnancy/ # weeks:	Was anesthesia used at delivery? ☐ Yes ☐ No	What kind?

Overdue	☐	How late?	
Length of labor		Described as easy	☐
Difficult	☐	Birth was spontaneous	☐
Required forceps	☐	Caesarean	☐
Infant was born head first	☐	Breech/specify	☐
Birth weight of infant		Birth length	
Was he/she yellow? ☐ Yes ☐ No		Infant required oxygen	☐
Blood transfusion	☐	Other medical attention	☐
Infant had difficulty breathing	☐	Vomited	☐
Was irritable	☐	Was mother and infant discharged from hospital together? ☐ Yes ☐ No	
If not, when did infant leave hospital:		_____Days _____Weeks _____Months	

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 SUREGERY			
DATE	**REASON**	**DATE**	**REASON**

DRUG ALLERGIES		CURRENT MEDICATIONS	

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
☐ hemorrhoids
☐ hernia
☐ 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

☐ nose bleeds
☐ vision – failing

☐ other _____

☐ other _____

☐ other _____

FAMILY MEDICAL HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
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 _____
Fate 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

School | Dates or Grades | Placement Type

Has your child repeated any grades? If yes, explain:

Most recent Achievement Test:
Type | Date | Results

What are your child's academic/school strengths (i.e.: favorite subjects, involvement in school activities, helpful, attentive, obeys rules, etc.):

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

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

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