BIOPSYCHOSOCIAL INTAKE ASSESSMENT & CLIENT INFORMATION - MINORS

Demographic Information

Name: _____

Date: _____ DOB: _____ Age: _____ Gender: _____

Street Address:

_____

City: _____ State: _____ Zip Code: _____

Name of parent(s)/guardian(s) who have legal custody of child:

_____

* *Address if parent/guardian lives in another residence:*
Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____
Is it ok to leave a voicemail? *YES* *NO*

Email Address: _____
Is it ok to email you? *YES* *NO*

How were you introduced to us? _____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one?

1. _____
2. _____
3. _____

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What do you think your child would say their biggest concern(s) is/are?

_____

_____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____

_____

_____

Have you or your child(ren) had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results.

_____

_____

Change is Coming…

What are your expectations from therapy and the therapist?

_____

_____

List concrete changes you would like to see happen during the course of therapy:

_____

_____

What other things would you like to see change in your life and your family's life?

_____

_____

Do you foresee any obstacles to achieving your goals/changes?

_____

_____

How long will therapy need to last to achieve the changes/goals you want? Write down a target date: _____

List 5 strengths about your child, give examples of each:

1. _____
2. _____

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3. _____
4. _____
5. _____

Medical Background

Has your child ever received psychiatric services before? YES NO
If yes, how long ago, with whom, for what, and results:

_____
_____

Many parents have opinions on psychiatric medications, what are yours?

_____
_____

Does your child have any allergies (food, environmental, medicinal, animal, etc.)

_____
_____

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

_____
_____

Is your child presently under a physician's care? If so, for what?

_____
_____

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:

_____
_____

Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

_____
_____

Tell us about your child's development milestones (delayed, on time, early)

_____

_____

Important Questions We Must Ask

Has your child ever had thoughts of killing themselves? YES NO
If yes, please explain:

_____

_____

Has your child ever planned on killing themselves? YES NO
If yes, please explain:

_____

_____

Has your child ever attempted to kill themselves? YES NO
If yes, please explain:

_____

_____

Has anyone in your family or close to you died by suicide? YES NO
If yes, please explain:

_____

_____

Has your child ever felt like they wanted to seriously hurt or kill someone else?
If yes, please explain: YES NO

_____

_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____

_____

Is there any past or present abuse or violence? YES NO

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If so, please explain:

_____

_____

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

_____

_____

Has your child ever witnessed or experienced a trauma? Have reoccurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? If so, please explain:

_____

_____

Are you concerned your child may see or hear things that don't appear to be real? If so, please explain:

_____

_____

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put them at risk? If so, please explain?

_____

_____

Do you have any concerns about your child's sexuality, gender or sexual development?

_____

_____

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or received specialized academic services? If so, for what?

_____

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc)?

_____

_____

What would your child say they likes and dislike about school:
Likes: _____
Dislikes: _____

What responsibilities does your child have at home?

_____

_____

If your child is age 15 yr. and above what skills do you think your child needs to be independent? How are they learning them? What else do they need to gain independence?

_____

_____

What other responsibilities or skills would you like to see your child have/achieve?

_____

_____

Does your child have their own cell phone? YES NO

What are the rules around your child's cell phone use? Who enforces those rules?

_____

Understanding Your Family

** Space left for therapist to draw family tree (genogram)*

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Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

If 1 or both parents are absent, if so for how long and reason for absences:

_____

_____

If parents are not together please describe the parents' relationship with one another:

_____

_____

Who lives in the house with the child?

_____

_____

If parents are not together who lives in the other house with the child?

_____

_____

Does your family have any pets? If yes, names, types and relationship to each pet:

_____

_____

List 5 or more strengths of your family:

_____

_____

Is there anything that gets in the way of your family being the way you want it to be?

_____

_____

Name, relationship and description of relationship below:

Parent 1:

_____

Parent 2:

_____

Step-parents or parent's significant other:

_____

Siblings: Age, Name and Sex:

1. Sibling 1

   _____
2. Sibling 2

   _____
3. Sibling 3

   _____
4. Sibling 4

   _____

Other important relationships:

_____

_____

Does your family belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?

_____

_____

Who else do you consider to be part of or supportive to your family (people or affiliations):

_____

_____

Is there anything else that you think is important for me to know about your child?

_____

_____

_____

_____

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