Clients ID ___________

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Clinical Biopsychosocial Assessment and Treatment Plan (Child/Adolescent)

Name: ___________________________ Age: _______________
Date of Birth: ____
Address: ____
Parents Names: ____
Addresses: ____
____
____
Mother telephone number: ________________________________
Father telephone number: _________________________________
Email: ____
Can you receive mail at this address? ______________________________
Can we call you at home: ______ At work?_______ Email? ______________
Can messages be left on your machine? At home?_______ At Work? _____
School:___________________________ Grade: _______________
Teacher:__________________________ Sch Counselor:________________
Siblings: __________________________ Age: _______________
__________________________ Age: _______________
__________________________ Age: _______________
__________________________ Age: _______________
Pediatrician Name/Phone: ____
Do you want us to contact your pediatrician: ___________
Pediatrician Name: ____________________________ Phone number: _________________

Describe household where child lives:

Two Parent Home
- ____ 2 biological parents
- ____ 2 adoptive parents
- ____ Biological mom with stepfather
- ____ Biological dad with stepmother
- ____ Other ______________________

One Parent Home
- ____ Biological dad only
- ____ Biological mom only
- ____ Other single male parent
- ____ Other single female parent

Other living arrangements:
_______Grandparents

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________ Relatives
________ Foster home
________ Group home
________ Institution
________ Other:________________________________

Who else lives in the home?

____
____
____

Where was your child born? ____________________________________
Hospital Name: ____
Birth Weight: ____
Type of Birth? ____

Were there complications during pregnancy? Yes No

____
____
____

Were there complications during delivery? Yes No

____
____
____

How would you describe your child as an infant?

____
____
____

At what age did they:

Walk ____ Toilet Train _____
Talk ____ Start School _____

Significant illnesses/medical or physical problems your child has:

____
____
____
____

Medications:

____
____

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____
____

Has your child been involved previously with individual, group or family counseling?

Yes __________ No ____________

When? ______________________________
Where? _______________________________
With whom? ____________________________
How long? _____________________________
Results?
____
____
____

Religious Affiliation: ____
How would you rate your religion in your child's life? ____________________

Culture: ____________________________
Clients Preferred Language: ____

Strengths/Hobbies:
____
____
____

Which of the following is your child experiencing?

_____ Bedwetting
_____ Encopresis
_____ Day Dreaming
_____ Poor Weight Gain
_____ Problematic Eating
_____ Allergies/asthma
_____ Headaches
_____ Stomach aches
_____ Head banging
_____ Hair pulling
_____ Destructive Behavior
_____ Stealing
_____ Starting fires
_____ Drug Use
_____ Alcohol Use
_____ Running Away

_____ Sibling Rivalry
_____ Excessive Crying
_____ Fear of Strangers
_____ Separation Problems
_____ Excessive activity
_____ Easily distracted
_____ Short attention span
_____ Difficulty completing work
_____ Fighting/Aggressive behavior
_____ Trouble making friends
_____ Trouble keeping friends
_____ Irritability
_____ Low self esteem
_____ Over critical of self
_____ Easily distressed
_____ Self destructive behavior (cutting,

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_____ Truancy

_____ School discipline problems

_____ Hurting Animals

suicide attempt)

Does your child have difficulty sleeping?

_________Yes _______No

Bedtime _______ Awake time_______

Which of the following apply?

_______Nightmares/terrors

_______Sleep walking

_______Frequent waking up during the night

_______Difficulty falling asleep

_______Very early riser

Where does you child sleep? ___________________________________

Does your child share a bed with anyone? _________________________

Does your child:	Yes	No
no longer enjoy things that he/she used to enjoy?	____	____
Strongly resist going to school	____	____
Get much lower grades that they used to	____	____
Play and spend time with friends less than they used to	____	____

Has your child ever:	Yes	No
attempted suicide	____	____
been expelled	____	____
been arrested	____	____
been declared delinquent	____	____
been in foster or relative care	____	____

Has your child experienced abuse of any kind, physical or sexual?

____

____

____

____

Has anyone from a child welfare agency ever worked with your children or your family?

____

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____
____

Which of the following has your child recently experienced?
Death of a parent or close relative ____________________
Death of a close friend ______________________________
Parental separation/divorce ____________________________
Major illness/hospitalization____________________________
Change in school ____________________________________
Change in residence__________________________________
School failure_______________________________________
Change in friends ____________________________________

Has your child witnessed domestic violence or animal abuse in the home?
____
____
____

Has your child witnessed drug or alcohol use in the home?
____
____
____
____

Is there a history of mental illness or suicide on either side of the family?
____
____
____
____

Is your child receiving special services in school?

	Yes	No
IEP/504	_____	_____
Special classes'	_____	_____
Special school	_____	_____
Tutoring	_____	_____

Comments:
____
____
____

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Does your child have any of the following?

	Yes	No
Learning disability	_____	_____
Mental retardation	_____	_____
Speech Therapy	_____	_____
Emotional Disturbances	_____	_____
Behavior Disorders	_____	_____
Physical Disorders	_____	_____

Comments:

Has your child ever received mental health treatment before?

Has your child ever received any type of psychological testing?

If so with whom, when, where?

SEPARATED/DIVORCED

Do you have court ordered custody arrangements? Yes _____ No ____
Sole _______ Joint _______ Other _______________________________________

Does the other parent agree to your request for therapeutic services?

Is the other parent required to be notified of medical care?

What is the name, address and telephone number of the noncustodial parent?

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How frequent does your child have contact with this parent?

____
____
____

What are the concerns about your child?

____
____
____
____
____
____

What brought you to therapy today?

____
____
____

When did these symptoms start?

____
____
____

What (if any) incident started the symptoms?

____
____
____

What would you like to accomplish in counseling?

____
____
____
____
____
____

Is counseling court ordered?

____
____

Who should be contact on your behalf? ____________________________________

Children Over 12 years old

Do you drink alcohol? ___________________

	Weekly	Daily
Beer		
Wine		
Hard Liquor		

Do your friends drink alcohol? __________________

Do you taken drugs or pills that are not prescribed by a doctor?

Have you ever received drug treatment?

Last time used

	Pot
	Cocaine (crack)
	Heroin
	Oxycodone
	Xanex
	Estacy
	Other
	Other

Do you find yourself concerned about your body shape or weight?

Have you ever been diagnosed with an eating disorder?

Do you ever do the following things to control your weight?

Vomit	Laxatives
Vigorous Exercise	Fasting
Strict Diet	Diuretics

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Are you sexually active?

____

Do you engage in safe sexual practices?

____

Arrest History:

____

____

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Mental Status:					
Appearance	Well Groomed	Disheveled	Bizarre	Inappropriate	Provocative
Attitude:	Cooperative	Guarded	Suspicious	Belligerent	Uncooperative
Motor Activity	Calm	Hyperactive	Agitated	Tremors Tics	Muscle Spasm
Impulse Control	Good	Impaired			
Intellect	Average	Above	Below		
Memory	Immediate	Recent	Remote		
Concentration	Intact	Impaired			
Attention	Intact	Impaired			
Behavior	Appropriate	Inappropriate			
Mood	Euthymic	Anxious	Euphoric	Depressed	Apathetic
Affect	Appropriate	Labile	Expansive	Blunted	Flat
Orientation	Fully Oriented	Impaired	Time	Place	Person
Speech	Normal	Delayed	Pressured	Incoherent	Perseverating
Insight	Intact	Impaired	Minimal	Moderate	Severe
Judgment	Intact	Impaired	Minimal	Moderate	Severe
Suicidal Ideation	Yes	No			
Homicidal Ideation	Yes	No			

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Risk Assessments:

Suicidal Ideation – check all that apply

None noted
Thoughts only
Frequency of thoughts
Plan
Intent
Means
Attempt
Active or passive
Chronic or acute

Comments:
____
____

Homicidal Ideation – check all that apply

None noted
Thoughts only
Frequency of thoughts
Plan
Intent
Means
Attempt
Active or passive
Chronic or acute

Comments:
____
____

Safety Plan_____ Involuntary Hospitalization _____Referral to Psychiatrist ____

Initial Diagnostic Impression:
Clinical: ____
____
____
Medical: ____
____

Stressors: ___Family ____School _____Work _____Health _____Legal
_____ Mild ______Moderate ______ Severe

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Clinical Impression

____
____
____
____
____
____
____

Clinician's Signature: ______________________________________

Date: ______________________

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Initial Treatment Plan

Client's Name: ___________________________________

Diagnosis Code: _________________________________

What I would like to accomplish in therapy? (Goals):

Goals should be individualized, strength-based, and appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the recipient

Goal 1. ____

____

Goal 2. ____

____

Goal 3. ____

____

How am I going to accomplish these goals? (Objectives)

(*Measurable objectives with target completion dates that are identified for each goal)*

Objective 1.

____

____

Target completion date: _______________________________________

Objective 2.

____

____

Target completion date: _______________________________________

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Objective 3.

____

____

Target completion date: ____

Services to be Provided:	Duration Per Week/Month
Psychotherapy	
Family Therapy	
Group Therapy	
TBOS	
Case Management	

How I will know that I am ready to stop therapy? (Discharge criteria)

1. ____
2. ____
3. ____

Client Signature: ____

Client Guardian Signature: ____

Clinician Signature: ____

Clinician Superviser Signature: ____