48 S. Market St.
Elizabethtown, PA 17022

Linden Blossom Counseling

Child/Adolescent Biopsychosocial Questionnaire

Today's Date: ________________

Child's Name: ______________________________________ Child's Age: ______________

Date of Birth: _____________________ Form completed by: ______________________________

Presenting Problem

What are the main concerns that bring you to therapy?

____
____
____
____
____
____
____
____

How long has this been a concern? ____
____
____

What strategies have been used to address the problem?________________________________
____
____
____
____

What are your goals for therapy?

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____
____
____
____

Please review the following list of common symptoms and circle or mark those that are of concern for your child.

Depression/Sadness	Withdrawn	Low Self Esteem	Loss of Interests
Self Injurious Behaviors	Poor Sleep Patterns/Nightmares	Poor Social Skills	Defiant/Uncooperative
Anger Problems	Aggression Towards Others	Drug/Alcohol Use	Over Sexualized Behaviors
Poor Self Control	Destruction of Property	Hyperactivity	Inattentive/Poor Focus
Excessive Fears/Worry	Bedwetting or Encopresis/Enuresis	Hallucinations/Delusions Or Dissociations	Regressive Traits/ Immature for Age
Physical Symptoms	Lying	Change in Grades	Change in Appetite

Traumatic childhood events such as abuse, neglect, and witnessing experiences like crime, parental conflict, mental illness, and substance abuse can result in long-term negative effects on learning, behavior and health (from the ACES study).

Sudden loss of a family member or pet	Frequent moving	Planned or unplanned time away from child	Parental conflict/divorce
Witness to community violence	Natural disasters	Witness to domestic violence	Someone who is chronically medically ill
Someone who is chronically depressed or suicidal living in the household	Alcohol or drug abuser in the household	Incarcerated family member	Life threatening events or accidents
Physical abuse	Emotional Abuse/Neglect	Sexual abuse	Military deployment

Additional information about circled concerns:____

____

____

____

____

____

Risk Assessment

Risk Assessment	Yes/No	Explain
Has your child ever made suicidal statements or made suicide attempts?		
Has your child ever intentionally harmed an animal/pet?		
Has your child ever engaged in self-harming behavior?		
Do you have concerns that your child may be using drugs or alcohol?		

Past Counseling/Therapeutic Services

Dates received/attended	Provider/Agency	Phone/Address	Diagnosis (if assigned)

Has anyone in your family or extended family ever had psychotherapy or counseling before?
Yes/No ____
____

Family Information

Please list family members that live in the home with child (and pets):

Name	Relationship	Age	Describe their relationship with child.

Other immediate family members that live outside of the home (i.e., parents or siblings):
____
____
____

Indicate primary caregivers' relationship status:

- ○ Married
- ○ Single
- ○ Partnered
- ○ Separated
- ○ Divorced

Are there family members or others that you consider part of your family's support system?
____
____
____

History of CPS or alternate placements (kinship, foster, group home)? Yes/No Please describe.
____
____

Does your family actively participate in religion/spirituality? Yes/No (If yes, where?) Is your child involved in the youth program?____
____

Medical History

Primary Care Doctor or Pediatrician (Name/Address/Phone Number):______________________
____
____

Please list any medications your child is taking at this time:

Name of medication	Dosage	Reason for taking	Prescribing Physician

Is your child up to date on their vaccinations? ____________________
Date of last physical exam: ______________

Has your child ever been bitten by a tick? _______________
Any history of head injuries/allergies/surgeries?______________

Please describe any past and present medical concerns or serious illnesses:________________
____

Are you aware of any sensory processing issues that your child has? Yes/No (Please describe.)
____

Are there any extended family members who have been diagnosed with a mental health disorder? Identify family member's relationship to your child and the medical condition:
____
____
____
____

Is there any family use of alcohol or drugs? Yes/No (Please describe).
____
____
____

Developmental History

Were kids always a part of your life plan? ___________
How many total pregnancies have you had?______
Any history of infertility, miscarriages, and/or stillborn losses? ______________________________
Term of pregnancy: _____ months Birth weight:___________

Were there any complications with the pregnancy or delivery? (i.e., time spent in the NICU? Ongoing medical issues as a result?) Yes/No (Please describe.) ___________________________
____

During pregnancy, was there any use of drugs/alcohol, exposure to domestic violence, major illnesses/accidents, or significant stressors? Yes/No (Please describe.) _____________________
____

Please list approximate ages when child reached the following milestones:

Speaking	
Walking	
Potty Trained	

Any problems with feeding or sleeping? Yes/No (Please describe)__________________________
____

	Concerns regarding development or peers?	**Significant stressors?**	**Temperament of child?**	**Peer/teacher relations?**
Ages 0-3				
Ages 4-6				
Ages 7-12				
Ages 13-18				

What technology/social media does your child have current access to? ____________________
____
____

How is technology monitored in the home? ____
____
____

Any issues of bullying either online or in school? (communicating with strangers, etc)
____
____

School Information

Current school and grade:____

What schools has your child attended in the past? ______________________________________
____

Has your child been identified as having a learning disorder? Any accommodations for learning? Yes/No (IEP, 504, OT/PT, speech)
____
____

Has your child ever received speech therapy or occupational therapy? Yes/No (If yes, please describe.)____

____

Do you have concerns about your child's behavior at school?_____________________________
____

What activities or clubs is your child involved in?_____________________________________
____

Child Management

Mark the methods do you generally use for discipline of your children?
Time out_____ Discuss with child______ Lecture_____ Remove privileges_____
Add chores_____ Spank_____ Send to room (alone)_____
Are you consistent with your discipline? Yes/No (If no, please describe.) __________________
____

How does your child typically respond when disciplined? ________________________________
____

What do you consider to be your family strengths? What do you feel that you need to improve or change as a family?____
____
____
____

Additional Information

What are some of the strengths and positive qualities of your child?_______________________
____
____
____
____

Is there any other information that I should know regarding your child or family?_____________
____
____
____
____