Abbey Counseling
Child/Adolescent BioPsychoSocial Assessment
(for parent and/or child/adolescent to complete)

Today's Date:_____

Child's Name:_____ Child's Age_____ Date of Birth:_____
Parent/Guardian Name_____
School Child Attends: _____ School Release Signed? __yes __no
What grade is your child in?_____ (see release in packet)

Top 3 Concerns/Reasons for Seeking Services: (Please note when these concerns first started for your child , ex: age 3 after attending a friend's birthday party)

_____
_____
_____
_____
_____
_____
_____

Who resides in the home? (Please list names/ages/relationship to the child). Any Pets?
Parents/Guardians- What is your occupation?

_____
_____
_____
_____
_____
How does everyone get along?_____
_____
_____

Here is a list of common symptoms – please feel free to circle those that concern you about 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Depression/Sadness	Withdrawn	Low Self Esteem	Loss of Interests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

Has your child ever had counseling before? Y N Any psychiatric hospitalizations? Y N
If Yes please note where and the dates of service: _____
_____
_____
Any involvement in the legal system Y N On probation? Y N
If yes, please explain below;
_____
_____

Family Dynamics:

Family History of Mental Health Concerns: _____
_____
_____
_____

Family History of Drug/Alcohol Concerns: _____
_____
_____
_____

Who typically disciplines the child? _____
How does that discipline typically look in your household? (Circle those that apply)

Remove Privileges	Add Chores	Yell/Scream/Shout	Lecture
Time Out	Ignore	Discuss Situation with Child	Spank with Hand
Spank with Object	Send to Room (alone)	Other:	

Are you consistent with your discipline? _____
_____
_____
How does your child typically respond when disciplined? _____
_____
_____

Risk Assessment

Has your child ever had thoughts of harming his/herself? Y N
If yes – has your child had a plan to do so? _____
Has your child ever attempted to harm his/herself? Y N Attempted to harm others? Y N
Has you child ever intentionally harmed an animal/pet? Y N
Did you ever have to call Crisis Intervention for you child? Y N
If yes to any questions above, please explain below:
_____
_____
_____
_____

History of Substance Use/Abuse

Has your child used/are using the following (circle all that may apply/add other info as needed):

Alcohol	OTC med abuse	Inhalants	Cocaine	Caffeine
Rx med abuse	Heroin/opiates	Synthetic/Club drugs	Marijuana	Cigarettes
Hallucinogens	Other			

Received any drug/alcohol assessments or treatment? Y N If yes, where?_____

Medical Information

Is your child currently on any medications? Y N If yes please list below and who prescribes:

_____
_____

Please list any current medical issues, history of medical hospitalizations for medical issues or any histories of head injuries:

_____
_____
_____

How was the pregnancy/delivery with the child? Any complications? Time spent in the NICU? Ongoing medical issues as a result?

_____
_____
_____

Developmental Milestones: (Please note if your child was on time, delayed or early)
Speaking: ___ on time ___ early ___ delayed (at what age?) _____
Walking: ___ on time ___ early ___ delayed (at what age?) _____
Potty Trained: ___ on time ___ early ___ delayed (at what age?) _____
Females- menstruating? Y N Age at first period_____

Any ongoing issues with bathroom/bedwetting?_____ If yes please describe below:

_____
_____
_____

Trauma History

Below is a list of common stressors for children. Please circle if your child has experienced any of the following and feel free to elaborate:

Sexual Abuse	Physical Abuse or Neglect	Emotional Abuse or Neglect	Witness to Domestic Violence
Sudden Loss of a Family Member (or Pet)	Incarcerated Family Member or other Abandonment	Frequent Moving or Homelessness	Witness to Community Violence
Alcohol or Drug Abuser in Household	Someone who is Chronically Depressed/Mentally Ill or Suicidal Living in the Household	Comments/Other:	

School History

Please note any issues experienced in the school setting (examples include: grades changing drastically, behavioral concerns at school, social difficulty, bullying, etc)

_____
_____
_____
_____
_____
_____

Is your child involved in any extra curricular activities either inside of school, church or outside of the school setting? (sports, music, clubs, youth groups, employed, etc).

_____
_____
_____
_____
_____

What technology does your child have current access to? Please circle those that apply:

Smart Phone	Computer with Internet Access	Facebook Account	Twitter Account
Instagram Account	SnapChat Account	Video Game System(s): (which ones?)	
IPad	Other:		

How is this technology monitored in your home? _____
_____

Do you have password access? _____ How does your child primarily communicate with their friends? _____

Have there been any issues with your child being bullied or bullying others online? Y N
If yes, please explain _____

Any other online issues? (communicating with strangers, etc) _____
If yes – please describe: _____
_____
_____

Additional Supports

Please make note of any additional supports your child has in his/her life that they have regular access to (grandparents, other family members, best friends, coaches, youth advisors, etc)

_____
_____
_____
_____

Strengths

Please tell us some of your child's biggest strengths. What are the best things about him/her? _____
_____
_____
_____

What are his/her favorite things to do for fun? _____
_____
_____

Is there anything else you would like us to know about your child?

_____
_____
_____
_____
_____
_____

Please stop here- the remaining part of the assessment form is for your therapist to complete.

Therapist Treatment Recommendations/Notes:

Provisional Diagnosis:
Axis I:_____
Axis II:_____
Axis III:_____
Axis IV:_____
Axis V:_____ Highest in past year: _____

Next appt:_____

Assessment Done by:_____

Printed Name:_____