Patient's Name _____

Child and Family Counseling Clinic
Biopsychosocial History Information

Today's Date: _____

PATIENT DEMOGRAPHICS

Patient's Name: _____ Sex: ◯M ◯F Birth Date: _____

Primary Language Spoken: _____ Age: _____ Ethnicity _____

School: _____ Grade: _____ Occupation _____

Teacher's Name: _____ Phone: _____ Email: _____

School Counselor's Name: _____ Email: _____

Handedness _____

Does the patient wear glasses? ◯Yes ◯No

Person filling out this form and relationship to the patient:_____/_____

Who referred you? _____Relationship of the referral to the patient? _____

Based on the reason for referral of the person who referred you/ the patient for services, do you agree with the referral? ◯Yes ◯No
Please explain: _____
_____
_____

Is this referral related to any type of legal or court proceedings? ◯Yes ◯No
If yes, please explain:
_____
_____
_____

Do you plan to have the patient's clinician testify in court proceedings? ◯Yes ◯No
If yes, please explain:
_____
_____
_____

Patient's Name _____

PRESENTING ISSUE(S):

Briefly describe the patient's current difficulties: _____
_____
_____

How long has the patient had problem(s) for which you are seeking help?

◯ 0-1 month ◯ 1-3 months ◯ 3-6 months ◯ 6-12 months ◯ 1-2 years ◯ 2-4 years

Other: (please indicate) _____

Please rate the intensity of the problem(s) or concern(s) that you have in reference to your child?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Low High

Please indicate the frequency with which the problem(s) occur:

◯ Daily ◯ Weekly ◯ Monthly ◯ Seasonal ◯ Specific event(s) ◯ Specific place(s)

◯ Other _____

Describe the behaviors of your child and the impact on the following environments (please describe the most recent period(s) of time):

Home:_____
_____
_____

School:_____
_____
_____

Other social environments:
_____
_____
_____

What have you done in an attempt to resolve the problem and what results/outcomes and what changes have developed in response to the problem over time? Please explain in detail:
_____
_____
_____
_____

Patient's Name _____

Who are the caregivers involved in the patient's life on a daily/weekly basis (list all that apply): Name/Relationship:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Has the patient been seen previously by a:

Professional	**Yes**	**No**	**Name of Professional**	**Date(s) of Service**	**# of sessions**	**Currently Seeking Services? Y or N**	**If yes, Frequency (days of the week, times)**
Psychiatrist							
Psychologist							
Speech Pathologist							
Audiologist							
Physical Therapist							
Occupational Therapist							
Social Worker							
School Counselor							
Learning Specialist							
Tutor							
ABA Therapist							
Hospitalized for Psychiatric Care							
Other							

Is the patient adopted? ◯Yes ◯No Date of adoption: _____

If yes, was the adoption open or closed? _____

If yes, what does the patient know (if anything) about his/her adoption? _____
_____
_____.

Patient's Name _____

FAMILY HISTORY

Marital Status of Parents: ◯ Married ◯ Separated ◯ Divorced ◯ Never Married/Living Together

◯ Never Married/Living Apart ◯ Remarried ◯ Other

If parents are separated or divorced, how old was the patient when the separation occurred?_____

Please describe events which led up to the divorce and events that your child was exposed to (include arguments, fighting, violence if applicable, etc)_____
_____

The next set of questions primarily focuses on children whose parents have/are separated and/or divorced:

What is the custody schedule? _____

Which adult does the patient live with? _____
How long has this current situation been? _____

Is the patient happy/content with this situation?_____

Why & How Can You Tell? _____
_____
_____

For all parents:
Describe your current spousal relationship (applicable for parents who are married, not married, separated and/or divorced):_____

Whom is the patient closer with (parent/grandparent/other)?
_____

Would you describe the patient as "distant" from any one particular parent/grandparent/other?
_____

Family Constellation: (List all people living in household. Include all family members (parents, siblings) that have frequent contact with the patient (i.e., weekly, and bi-weekly) such as maternal grandmother, half siblings, stepmother, etc.)

Name	Relationship to the patient	Age	Frequency

Patient's Name _____

Describe the patient's daily and weekly routine: (school schedules, activity schedules, other):_____
_____
_____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Wake Time							
Morning Routine							
School Times							
After School Event/Times							
Evening Routine							
Bed Time							

Who is primarily responsible for your child? (Mom? Dad? Both? Describe): _____
_____
_____

What kind of physical exercise does your child get? _____

What kind of play is your child involved in? _____

_____

What kind of "down" (i.e., no physical activity, TV, Screen time) time does your child get? How long?
_____

What kind of screen time does your child get? How long? What does he watch? What does he play?
_____

Does the patient have difficulties with sleep? (*please check the yes or no box)* ◯ Yes ◯ No

Please check items that apply: (explain)

- ☐ Oversleep _____
- ☐ Cannot go to sleep _____
- ☐ Nightmares _____
- ☐ Frequent awakenings _____

Does the patient have problems with appetite? ◯ Yes ◯ No

Please check items that apply: (explain)

- ☐ Decreased appetite _____
- ☐ Loss of weight _____
- ☐ Overeating _____
- ☐ Binging _____
- ☐ Forced vomiting _____
- ☐ Use of laxatives _____

Patient's Name _____

Does the patient have problems with his/her activity level? ◯ Yes ◯ No

Please check items that apply: (explain)

- ☐ Decreased energy _____
- ☐ Increased energy_____
- ☐ Loss of interest _____
- ☐ Increased interest in danger

(seeking activity, explain) _____

Does the patient have problems with attention or concentration?

◯ Yes ◯ No

How much caffeine does the patient consume each day? _____

Dangerous behavior?

1. ◯ Yes ◯ No Does the patient have access to a weapon?
2. ◯ Yes ◯ No Has the patient ever made attempts to harm himself? When: _____
3. ◯ Yes ◯ No Is the patient talking about harming someone else? If so, explain: _____
4. ◯ Yes ◯ No Has the patient ever attempted to harm someone else? If so, explain: _____

Has the patient ever made an attempt to harm him/herself, or others? Threatened to do so? Explain.

_____

_____

Difficulty with Siblings? (Arguing, fighting, jealousy)_____

_____

_____

Method of Discipline Currently Used (include both caregivers):

☐ spanking ☐ fussing ☐ screaming ☐ taking privileges away ☐ Timeout

☐ rewards ☐ other _____

Is your method of discipline effective? _____

Who is the main disciplinarian at home? _____

Do both parents discipline similarly? Differently? _____.

Have there been any recent changes in the family system and if yes for how long? (i.e., change in home location, major events, significant losses, etc.)

_____

_____

_____

Patient's Name _____

____ # of times the family has moved since the child was born? Reasoning: _____
_____

Family Religion: ◯ Catholic ◯ Protestant ◯ Jewish ◯ Lutheran ◯ Episcopalian

◯ Non-Denomination ◯ Atheist ◯ Science Christian ◯ Other

Are there any cultural/spiritual beliefs that you may have that you believe will impact your child's therapy?_____
_____

Check the activities in which your child participates with the family:

Activity	**YES?**	**Frequency**	**Level of Child's Enjoyment**
Movies			
Meals			
Conversations			
Visits with Relatives			
Church			
Games			
Sports			
Trips			
TV			
Out to Dinner			
Other			

What do you feel your strengths as a family are? _____
_____

What would you like to change in your family? _____
_____

What do you enjoy most about this child?
_____
_____
_____

What do you find most difficult about raising this child?
_____
_____

What would you like for the patient to be when he/she grows up? _____

Highest grades completed in years: _____ Mother _____Father

Household Income provided by: ____ Mother _____Father _____ Other family members _____SSI _____Other

What level of education do you hope the patient will complete? _____

Patient's Name _____

Place a check next to any illness or condition that any member of the immediate family has had. When you check an item, please note the member's relationship to the patient.

Illness/Condition	YES?	Family Member Name/ Relationship to Child	Past Issues or Current Issues?	Seeking Professional Services? Y or N	Type of Illness/ Condition
Alcoholism/Substance Abuse					
Cancer					
Genetic Disease/Condition					
Diabetes					
Sickle Cell Anemia					
Kidney Problems					
Thyroid Problems					
Seizures					
Serious Illness					
Debilitating injuries/disabilities					
Heart Trouble					
Nervous/Psychological Problems					
Psychiatric Problems					
Depression					
Anxiety					
Physical/Sexual Abuse					
Emotional Abuse/Neglect					
Suicide Attempt					
Suicide Completion					
Infectious Diseases					
Other					

Please check any past, present, or impending special problems in your family:

Issues	**YES?**	**Family Member Name/ Relationship to Child**	**Past Issues or Current Issues?**	**Seeking Professional Services? Y/ N**	**Type of Illness/ Condition**	**Other Comments**
Divorce						
Gaming						
Gambling						

Patient's Name _____

Issues	YES?	Family Member Name/Relationship to the patient	Past Issues or Current Issues?	Seeking Professional Services? Y / N	Type of Illness/Condition	Other Comments
Legal Problems						
Frequent Relocations						
Financial Crisis						
School Problems						
Learning Problems						
Attention Problems						
Truancy						
Deaths						
New Children						
Marital Strifes						
Other						

Do you (parents or child) smoke? ◯ Yes ◯ No If yes, do you smoke in the household? ◯ Yes ◯ No

PLEASE ANSWER FOR BOTH CAREGIVERS IN THIS SECTION

CAREGIVER 1: (indicate who you are)_____

Have you personally experienced significant family abuse?_____

Have you personally experienced legal problems?_____

Did you experience learning problems in school?_____

In general, how happy or adjusted were you growing up?_____

How much is your immediate family a source of emotional support for you?_____

Who in your family do you feel closest to? _____

Most distant from? _____In most conflict with?_____

Social History:

_____

CAREGIVER 2: (indicate who you are)_____

Have you personally experienced significant family abuse_____

Have you personally experienced legal problems_____

Did you experience learning problems in school?_____

Patient's Name _____

In general, how happy or adjusted were you growing up?_____

How much is your immediate family a source of emotional support for you?_____

Who in your family do you feel closest to? _____

Most distant from? _____In most conflict with?_____

Social History:_____

EDUCATIONAL HISTORY

Has the patient had any academic, behavioral, or problems in school?

Problem	**Type**	**Severity Level (1 to 5)**	**Comments**
Academic			
Behavioral			
Peer Related			
Retention (repeated Grades)			

How did the patient perform academically/socially in each grade? (poor/fair/good/excellent):

	Academically	**Socially**
Daycare/Preschool/Headstart		
Elementary School		
Middle School		
High School		

Has your child ever been expelled/ suspended? ◉ Yes ○ No

Has your child ever been tested? ○ Yes ◉ No

Does your child have an IEP (individualized education plan)? ○ Yes ○ No

SOCIAL

Does your child have many friends (In/Out of School)? Who are they? _____
_____
_____

Does your child have difficulty making or keeping friends? _____
_____
_____

Patient's Name _____

What is your child's style like when making friends? Do you think his/her style is effective or not?

_____
_____
_____

Based on the patient 's style - Whose perception is this based on – yours (the parent), the teacher's (feedback/parent-teacher meetings), or both?

_____
_____
_____
_____

Has the patient been tested for learning disabilities? Special Education/Support Services?

_____
_____
_____

Please check where appropriate:

☐ Has difficulty with reading
☐ Has difficulty with spelling
☐ Other subjects: _____
☐ Does not like school
☐ Has difficulty with math
☐ Has difficulty with writing

PSYCHIATRIC HISTORY

Place a check for each symptom that applies to the patient (please make a note next to each item that you circle an explanation, the duration, and treatment history if any) :

Symptom	YES	Frequency	Intensity	Duration	List with Details
Fears					
Sadness					
Anger					
Irritation					
Explosive Outbursts					
Gets Upset Easily					
Cruel to Animals					
Sets Fires					
Breaks Things Belonging to Himself					
Breaks things Belonging to Others					
Decreased Energy					
Increased Energy					
Loss in Interest in Activities					
Increased Interest in Danger					
Risk Taking					

Patient's Name _____

Symptom	Y/N	Frequency	Intensity	Duration	List with Details
Oversleep					
Cannot go to Sleep					
Nightmares					
Night Terrors					
Frequent Awakenings					
Decreased Appetite					
Increased Appetite					
Overeating					
Binging					
Forced Vomiting					
Use of laxatives					
Smokes					
Uses/Abuse Drugs					
Self-Harm					
Performs Rituals					
Sees Things That Are Not There					
Obsessive Concerns					
Worries					
Hears Things That People Do Not					
Repeats Specific					
Repeats Behaviors Over and Over Again					
Suicidal Thoughts					
Homicidal Thoughts					
Depression					
Anxiety					
Dependent					
Concerns with Physical Problems					
Rapid Mood Changes					
Worthlessness					
Hopeless					
Poor Self-Esteem					
Stomach Aches					
Shy					

Patient's Name _____

Withdrawn					
Symptom	**Y/N**	**Frequency**	**Intensity**	**Duration**	**List with Details**
Wets Bed/Clothes					
Swears/Curses					
Fidgety					
Impulsive					
Hyperactive					
Steals					
Runs Away					
Can't Wait Turn					
Doesn't Share					
Doesn't Listen/Doesn't Follows Instructions					
Forgets					
Harms Self					
Harms Others					
Speech Difficulties					
Hearing Difficulties					
Language Difficulties					
Vision Difficulties					
Rocks Back and Forth					
Tantrums					
Bangs Head					
Bites Nails					
Pulls Hair/Eye Lashes					
Sucks Thumb/Fingers					
Overly Neat					
Perfectionism					

CHILD'S DEVELOPMENTAL HISTORY

Prenatal events: _____

Parents' attitude toward pregnancy _____

Conception – ease ◯ planned ◯ unplanned ◯

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc._____

Patient's Name _____

Birth and Postnatal period:

Birth weight _____Length _____Labor duration _____ Delivery: vaginal _____C section _____ Problems _____

APGAR scores (if known) _____ Any jaundice? ◯Yes ◯No Time in hospital _____

Complications?_____

Mother's health after delivery _____

Post Partum Depression? ◯Yes ◯No if yes, how long? _____

Primary caretaker for the patient, first year_____
thereafter _____

Feeding history: Age breastfeeding was weaned ____ Age bottle feeding was weaned _____

Food allergies _____

Separations from mother and/or father: age, duration, reaction to: _____
_____

Toilet training:
Age reached bowel control: day _____ night _____
bladder control: day _____ night _____
Toilet trainings methods used _____ ease _____ current function: Good/adequate/poor

Sexual development: Gender identity issues ◯Yes ◯No

Motor development: (please write in age, parentheses are approximate normal limits)

Rolls over (3-5m)_____sit without support (5-7m)_____crawls (5-8)_____ walks well (11-16m)_____

Runs well (2y)_____rides tricycle (3y)_____ throws ball overhand (4y)_____

Current level of activity _____

Fine and gross motor coordination _____ compared to peers _____

Language development: (please write in age, parentheses are approximate normal limits)

Several words besides dada, mama (1y)_____ name several objects-ball, cup (15m)_____

3 words together--subject, verb, object (24m) _____vocabulary _____articulation _____comprehension _____

Compared to peers _____

Any current problems _____

Patient's Name _____

Social development: (please write in age, parentheses are approximate normal limits) smile (2m) _____

shy with strangers (6-10m) _____separates from mother easily (2-3y) _____cooperative play with others (4y) _____

quality of attachment to mother_____ quality of attachment to father_____

relationships to family members _____
early peer interactions _____

current peer interactions _____

special interests/hobbies_____

Behavioral/Discipline: compliance vs. non-compliance _____

lying/stealing _____ rule breaking _____ methods of discipline _____

other problems _____

Emotional development: early temperament _____

current personality _____

mood _____ fears/phobias _____

habits _____

special objects (blankets, dolls, etc.) _____ ability to express of feelings _____

Drug/Alcohol History: _____
_____

School History: current grade _____ school contact _____

number of schools attended _____ average grades _____

homework problems _____

specific learning disabilities _____

strengths _____

what have teachers said about the patient _____

_____

Patient's Name _____

Overall Strengths & Challenges -- as viewed by parents

_____
_____
_____
_____

Overall Strengths & Challenges-- as viewed by the patient

_____
_____
_____
_____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes ◉ No ○
If yes, what kind?_____
During pregnancy, did mother smoke? Yes ○ No ◉
If yes, how many cigarettes each day? _____
During pregnancy, did mother drink alcoholic beverages Yes ◉ No ○
If yes, what did she drink and how often? _____
During pregnancy, did mother use drugs? Yes ○ No ○
If yes, what kind and how often?_____
Were forceps used during delivery? Yes ○ No ○
Was a Caesarean section performed? Yes ○ No ○
If yes, for what reason? _____
Was the child premature? _____
If so, by how many months? _____
What was the child's birth weight? _____
Were there any birth defects or complications? _____
If yes, please describe: _____
Were there any feeding problems? Yes ○ No ○
If yes, please describe: _____
Were there any sleeping problems? Yes ○ No ○
If yes, please describe: _____
As an infant was the patient quiet? Yes ○ No ○
As an infant, did the patient like to be held? Yes ○ No ○
As an infant, was the patient alert? Yes ○ No ○
Were there any special problems in the growth and development of the child during the first few years? Yes ○ No ○
If yes, please describe: _____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a questions mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	*Age*	*Behavior*	*Age*
Showed response to mother	_____	Put several words together	_____
Rolled over	_____	Dressed self	_____
Sat alone	_____	Became toilet trained	_____
Crawled	_____	Stayed dry at night	_____
Walked alone	_____	Fed self	_____
Babbled	_____	Rode tricycle	_____
Spoke first word	_____		

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from *BASC*
Revised by Erin M. Dugan, PH.D., LPC-S, RPT/S 2009; Revised by Erin M. Dugan, PH.D., LPC-S, RPT/S 2012, 2016, 2019

Patient's Name _____

Early Childhood

Child walked:	Child spoke words:	Child spoke sentence:
_____ < 12 months	_____ < 12 months	_____ < 12 months
_____ 12 – 24 months	_____ 12-24 months	_____ 12-24 months
_____ 24-36 months	_____ 24-36 months	_____ 24-36 months
_____ > months	_____ > months	_____ > months
_____ has never walked	_____ has never spoken words	_____ has never spoken sentences

highlight all that apply:

Infancy	Easy	Friendly	Easy going	Regular sleep patterns	Difficult	Slow to warm up	Fussy	Unpredict-able sleep patterns	
Toddlerhood	Active	Adventuresome	Can focus attention	Moody	Outgoing	Passive	Clingy	Distracted	Cheerful
Preschool	Separated Easily	Got Along with Peers	Got Along with Adults	Difficulty Separating	Problems with Peers	Behavior Problems			
Latency	Got Along with Peers	Problems with Peers	School Behavior Problems	Got Along with Adults	Poor Relationship with Teacher/ Adults	Performs Well at School			
Adolescence	Got Along with Peers	School Behavior Problems	Gets Along with Teacher /Adults	Problems with Peers	Performs Well at School	Poor Relationship with Teacher/ Adults	Has Several Friends		

Puberty

Onset of puberty (breast development, menstruation, pubic hair, facial hair):

- ◯ < 10 years
- ◯ 10-12 years
- ◯ 12-14 years
- ◯ 14-16 years
- ◯ > 16 years
- ◯ no development

MEDICAL HISTORY

Medical Illness	**Y/N**	**Details**
Seizures		
Head Injury		
Blurred Vision		
Thyroid Problems		
Dizziness		
Eye Problems		
Kidney Problems		
Allergies		
Hearing Problem		
Blood Transfusion		
High Fever		
Pregnancy		
Asthma		
Diabetes		

Heart Problems		
Hospitalizations/Surgeries		
Serious Illness		
Loss of Consciousness		
Digestive Problems		
Blood in Urine		
STD		

Other:
_____
_____

Does the patient have a Primary Care Physician (PCP): Yes ◯ No ◯
Current Prescribed Medications/Reasons:

Type:_____ Type: _____
Dose: _____ Dose: _____
Frequency:_____ Frequency: _____
Reason: _____ Reason: _____

Pediatrician Name: _____ Contact #: _____

LEGAL HISTORY

Physical Abuse ◯ Yes ◯ No Describe: _____
_____
Date of Report: _____

Sexual Abuse ◯ Yes ◯ No Describe: _____
_____
Date of Report: _____

Sexual Abuse Yes ◯ No ◯ Describe: _____
_____
Date of Report: _____

Neglect ◯ Yes ◯ No Describe: _____
_____
Date of Report: _____

Was a Forensic Examination/Interview Taken? ◯ Yes ◯ No Date: _____
Interviewer _____ Phone: _____
Impending Court Appearance: ◯ Yes ◯ No Date: _____
Purpose: _____

Domestic Violence Shelter? ◯ Yes ◯ No Describe: _____
_____
Caseworker _____ Phone: _____
Orders of Protection: ◯ Yes ◯ No Describe: _____
_____

Patient's Name _____

Risk Factors:

A.

Do you believe that the patient uses drugs? Yes ◯ No ◯
Does the patient have friends that use drugs? Yes ◯ No ◯
Does the patient have a weapon? Yes ◯ No ◯
If yes, has he/she used it for reasons other than sports activities like hunting? (*explain)*

_____

Has he/she ever had a weapon? Yes ◯ No ◯

B.

Does the patient have friends who are in gang? Yes ◯ No ◯
Is he/she a member of a gang? Yes ◯ No ◯
If yes, what gang activities has he/she been involved in?

_____

Has the patient witnessed violence? Yes ◯ No ◯
If yes, explain: _____
Has he/she ever been arrested? Yes ◯ No ◯
If yes, how many times? _____, for what? _____
Has the patient ever been on probation? Yes ◯ No ◯
Name of Probation Officer _____
How many times? _____
What are the current charges?_____
Does the patient have friends who are involved in court? Yes ◯ No ◯

OTHER INFORMATION

What are the patient's favorite activities?

_____ _____ _____
_____ _____ _____

What activities would the patient like to engage in more often than he/she does at present?

_____ _____ _____

What activities does the patient like least?

_____ _____ _____

Has the patient ever been in trouble with the law? Yes ◯ No ◯
If yes, describe: _____
_____

CAREGIVER'S EXPECTATIONS OF SERVICES:

Patient's Name _____

What do you expect from receiving services for the patient? For yourself? Explain.

_____
_____
_____

What are your goals for the patient? For yourself? Explain.

_____
_____
_____.

How long do you believe the therapy should take for the patient's presenting issue(s) to be resolved? Explain.

_____
_____
_____.

What is your role as the patient's caregiver(s)? Please describe for both caregivers.

_____
_____
_____.

What stressors are evident in your lives?

_____
_____
_____.

What do you believe the role of the therapist is who will be providing services to the patient?

_____
_____
_____.

Is there any other information that you think may help us in working with the patient?

_____
_____
_____.

Caregiver(s) Name: _____ Signature :_____ Date:_____

Clinician's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____