CHILD AND ADOLESCENT BIOPSYCHOSOCIAL QUESTIONNAIRE

Please bring this completed form with you at the time of your first appointment at Thank you for your investment of time. This information will help us to give the best care possible.

Date you completed this form: _____
Person who completed this form: _____
Relationship to child: _____

It is preferable that both parents accompany the child to the first consultation, if possible.

Child's name _____ Birthdate _____ Age ____ Sex ____
last first middle

Home address _____
street city state zip

Home telephone number _____

Emergency Contact _____ Telephone _____

Child's school _____ Telephone _____
Name

_____ Grade _____
Address

Child's living situation (place check in appropriate box):

	Column A Adults with whom child is living	Column B Non-residential adults involved with child
Natural mother	☐ ___	☐ ___
Natural father	☐ ___	☐ ___
Stepmother	☐ ___	☐ ___
Stepfather	☐ ___	☐ ___
Adoptive mother	☐ ___	☐ ___
Adoptive father	☐ ___	☐ ___
Foster mother	☐ ___	☐ ___
Foster father	☐ ___	☐ ___
Other (specify)	_____ ___	_____ ___

Place the number 1 next to the child's primary residential caregiver (Column A above) and provide the following information:

1. Name _____ Occupation _____

   Business name _____ Business phone # _____

   Business Address _____

Client Name _____

Place the number 2 next to the child's secondary residential caregiver (Column A above) and provide the following information:

2. Name _____ Occupation _____

   Business name _____ Business phone # _____

   Business Address _____

Place the number 3 next to the person checked in Column B who is most involved with the child and provide the following information:

3. Name _____ Home phone # _____

   Home address _____

   Occupation _____Business name _____

   Business address _____ Business phone no. _____

If primary caregivers work outside the home, who cares for the child when caregivers are away?

_____

How many hours per week is this child in this child-care setting: _____

If child was adopted, how old when s/he was adopted? _____

If child is or was in foster care, describe number and quality of placements, along with length of time in each (please, use separate sheet of paper and attach).

Who referred you to EMERGE? Name _____

Address _____

_____ Phone no. _____

Pediatrician or family doctor _____

Address _____

Phone # _____ Date of last appointment _____

Reason for appointment _____

Why are you seeking counseling for this child now? (brief summary of the main problems, please include when the problems began and how long each lasted):

_____

_____

_____

_____

_____

Client Name _____

PREGNANCY

Duration of pregnancy _____ weeks

Complications:
❑ Excessive vomiting ❑ Hospitalization required

❑ Excessive staining or blood loss ❑ Threatened miscarriage

Infection(s) (specify) _____

❑ Toxemia ❑ Operation(s) (specify) _____

Other illness(es) (specify) _____

❑ Smoking during pregnancy Average number of cigarettes per day _____

❑ Alcohol consumption during pregnancy

Describe what and how often _____

❑ Drugs taken during pregnancy (please specify if prescriptions) _____

_____

❑ X-ray studies during pregnancy _____

DELIVERY

Mother's age at birth: _____ Father's age at birth: _____
Type of labor: ❑ Spontaneous ❑ Induced _____ Forceps: ❑ high ❑ mid ❑ low
Duration of labor: _____ hours Caesarean delivery ❑ Yes ❑ No

Complications:
❑ Cord around neck ❑ Cord presented first ❑ Hemorrhage ❑ Infant injured during delivery
Other (specify) _____

Birth weight _____
❑ Appropriate for gestational age (AGA) ❑ Small for gestational age (SGA)

Mother's condition at birth _____

Child's condition at birth _____

POST-DELIVERY PERIOD (while in the hospital)

Respiration: ❑ immediate ❑ delayed (if so, how long) _____

Cry: ❑ immediate ❑ delayed (is so, how long) _____

❑ Mucus accumulation ❑ Apgar score (if known) _____ ❑ Jaundice

Rh factor _____ ❑ transfusion ❑ Cyanosis (turned blue)
❑ Incubator care Number of days _____ Oxygen given? _____ How long? _____
Suck: ❑ strong ❑ weak

Infection (specify) _____
❑ Vomiting ❑ Diarrhea

Client Name _____

Birth defects (specify) _____

Total number of days baby was in the hospital after the delivery _____

INFANCY-TODDLER PERIOD

Were any of the following present to a significant degree during the first few years of life? If so, describe.

- ☐ Did not enjoy cuddling
- ☐ Was not calmed by being held and/or stroked
- ☐ Colic
- ☐ Excessive restlessness
- ☐ Diminished sleep because of restlessness and easy arousal
- ☐ Frequent headbanging
- ☐ Constantly into everything
- ☐ Excessive number of accidents compared to other children

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, check item at right.

	Age	I cannot recall exactly, but to the best of my recollection it occurred early	at the normal time	late
Smiled				
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words besides "ma-ma" and "da-da"				
Said phrases				
Said sentences				
Bowel trained, day				
Bowel trained, night				
Bladder trained, day				
Bladder trained, night				
Rode tricycle				
Rode bicycle (without training wheels)				
Buttoned clothing				
Tied shoelaces				
Named colors				
Named coins				
Said alphabet in order				
Began to read				

COORDINATION

Rate your child on the following skills:	Good	Average	Poor
Walking	☐	☐	☐
Running	☐	☐	☐
Throwing	☐	☐	☐
Catching	☐	☐	☐
Shoelace tying	☐	☐	☐
Buttoning	☐	☐	☐
Writing	☐	☐	☐
Athletic abilities	☐	☐	☐

Client Name _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? _____ If not, why not? _____

_____

How would you rate your child's overall level of intelligence compared to other children?
❑ below average ❑ average ❑ above average

SCHOOL

Rate your child's school experiences related to academic learning.

	Good	Average	Poor
Nursery school	❑	❑	❑
Kindergarten	❑	❑	❑
Current grade	❑	❑	❑

To the best of your knowledge, at what grade level is your child functioning:
Reading _____ Spelling _____ Arithmetic _____

Has your child ever had to repeat a grade? If so, when? _____

Present class placement: ❑ regular class ❑ special class (if so, specify) _____

_____

Kinds of special therapy or remedial work your child is currently receiving at school:

_____

_____

Describe briefly any academic school problems _____

_____

_____

Do you have concerns about the quality of your child's school or teacher? _____

_____

_____

Rate your child's school experience related to behavior:

	Good	Average	Poor
Nursery school	❑	❑	❑
Kindergarten	❑	❑	❑
Current grade	❑	❑	❑

Does your child's teacher describe any of the following as significant classroom problems?

- ❑ Doesn't sit still in his or her seat
- ❑ Frequently gets up and walks around the classroom
- ❑ Shouts out. Doesn't wait to be called upon.
- ❑ Won't wait his or her turn.
- ❑ Does not cooperate well in group activities
- ❑ Typically does better in a one-to-one relationship
- ❑ Doesn't respect the rights of others
- ❑ Doesn't pay attention during storytelling

Describe briefly any other classroom behavioral problems _____

_____

_____

Client Name _____

PEER RELATIONSHIPS

- ❑ My child seeks friendships with peers.
- ❑ My child is sought by peers for friendship.
- ❑ My child plays primarily with children his or her own age.
- ❑ My child plays primarily with younger children.
- ❑ My child plays primarily with older children.

Describe briefly any problems your child may have with peers. _____

_____

_____

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

- ❑ Hyperactivity (high activity level)
- ❑ Poor attention span
- ❑ Impulsivity (poor self-control)
- ❑ Low frustration tolerance
- ❑ Temper outbursts
- ❑ Sloppy table manners
- ❑ Interrupts frequently
- ❑ Doesn't listen when being spoken to
- ❑ Sudden outbursts of physical abuse of other children
- ❑ Acts like he or she is driven by a motor
- ❑ Wears out shoes more frequently than siblings
- ❑ Heedless to danger
- ❑ Excessive number of accidents
- ❑ Doesn't learn from experience
- ❑ Poor memory
- ❑ More active than siblings or peers

Most children exhibit, at one time or another, one or more of the symptoms listed below. Place a P next to those that your child has exhibited in the PAST and an N next to those that your child exhibits NOW. Only mark those symptoms that have been or are present to a significant degree over a period of time. Only check as problems behavior that you suspect is unusual or atypical when compared to what you consider to be the normal for your child's age. Then, on pages 8-9, list the symptoms checked off on pages 6-8 and write a brief description including age or onset, duration, and any other pertinent information.

____ Thumb sucking

____ Baby talk

____ Overly dependent for age

____ Frequent temper tantrums

____ Excessive silliness and clowning

____ Excessive demands for attention

____ Cries easily and frequently

____ Generally immature

____ Eats non-edible substances

____ Overeating with overweight

____ Eating binges with overweight

____ Undereating with overweight

____ Long periods of dieting and food abstinence with underweight

____ Preoccupied with food—what to eat and what not to eat

____ Preoccupation with bowel movements

____ Constipation

____ Encopresis (soiling)

____ Insomnia (difficulty sleeping)

____ Enuresis (bed wetting)

____ Frequent nightmares

Client Name _____

____ Night terrors (terrifying night-time outbursts)

____ Sleepwalking

____ Excessive sexual interest and preoccupation

____ Frequent sex play with other children

____ Excessive masturbation

____ Frequently likes to wear clothing of the opposite sex

____ Exhibits gestures and intonations of the opposite sex

____ Frequent headaches

____ Frequent stomach cramps

____ Frequent nausea and vomiting

____ Often complains of bodily aches and pains

____ Worries over bodily illness

____ Poor motivation

____ Apathy

____ Takes path of least resistance

____ Tries to avoid responsibility

____ Poor follow-through

____ Low curiosity

____ Open defiance of authority

____ Blatantly uncooperative

____ Persistent lying

____ Frequent use of profanity to parents, teachers, and other authorities

____ Truancy from school

____ Runs away from home

____ Violent outbursts of rage

____ Stealing

____ Cruelty to animals, children, or others

____ Destruction of property

____ Criminal and/or dangerous acts

____ Trouble with the police

____ Violent assault

____ Fire setting

____ Little, if any, guilt over behavior that causes others pain and discomfort

____ Little, if any, response to punishment for anti-social behavior

____ Few, if any, friends

____ Doesn't seek friendships

____ Rarely sought by peers

____ Not accepted by peer group

____ Selfish

____ Doesn't respect the rights of others

____ Wants things own way with exaggerated reaction if thwarted

____ Trouble putting self in other person's position

____ Egocentric (self-centered)

____ Frequently hits other children

____ Argumentative

____ Excessively critical of others

____ Excessively taunts other children

____ Complains often

____ Is often picked on and easily bullied by other children

____ Suspicious, distrustful

____ Aloof

____ "Wise-guy" or smart aleck attitude

____ Brags or boasts

____ Bribes other children

____ Excessively competitive

____ Often cheats when playing games

____ "Sore loser"

____ "Doesn't know when to stop"

____ Poor common sense in social situations

____ Often feels cheated or treated unfairly

____ Feels others are persecuting him/her when there is no evidence for such

____ Typically wants her or his own way

____ Very stubborn

____ Obstructionistic

____ Negativistic (does just the opposite of what is requested)

____ Quietly or silently defiant of authority

____ Feigns or verbalizes compliance or cooperation but doesn't comply with requests

____ Drug use

____ Alcohol use

____ Very tense

____ Nail biting

____ Chews on clothes, blankets, etc.

____ Head banging

____ Hair pulling

____ Picks on skin

____ Speaks rapidly and under pressure

____ Irritable, easily "flies off the handle"

____ Anxiety attacks with palpitations (heart pounding), shortness of breath, sweating, etc.

Client Name _____

FEARS

____ dark
____ new situations
____ strangers
____ being alone
____ death
____ separation from parent
____ school
____ visiting other children's homes
____ going away to camp
____ animals
____ other fears (name) _____

____ Disorganized

____ Tics such as eye-blinking, grimacing, or other spasmodic repetitious movements

____ Involuntary grunts, vocalizations (understandable or not)

____ Stuttering

____ Depression

____ Frequent crying spells

____ Excessive worrying over minor things

____ Suicidal preoccupation, gestures, or attempts

____ Excessive desire to please authority

____ "Too good"

____ Often appears insincere and/or artificial

____ Too mature, frequently acts older than actual age

____ Excessive guilt over minor indiscretions

____ Asks to be punished

____ Low self-esteem

____ Excessive self-criticism

____ Very poor tolerance of criticism

____ Feelings easily hurt

____ Dissatisfaction with appearance or body part(s)

____ Excessive modesty over bodily exposure

____ Perfectionistic, rarely satisfied with performance

____ Frequently blames others as a cover-up for own shortcomings

____ Little concern for personal appearance or hygiene

____ Little concern for or pride in personal property

____ "Gets hooked" on certain ideas and remains preoccupied

____ Compulsive repetition of seemingly meaningless physical acts

____ Shy

____ Inhibited self-expression in dancing, singing, laughing, etc.

____ Recoils from affectionate physical contact

____ Withdrawn

____ Fears asserting self

____ Inhibits open expression of anger

____ Allows self to be easily taken advantage of

____ Frequently pouts and/or sulks

____ Mute (refuses to speak) but can

____ Gullible and/or naïve

____ Passive and easily led

____ Excessive fantasizing, "lives in her/his own world"

____ Flat emotional tone

____ Speech noncommunicative or poorly communicative

____ Hears voices

____ Sees visions

As requested, please first list below symptoms from list above marked with the letter P (for past) and next to each symptom give descriptive information such as when symptom began, how long it lasted, and other important data. Then list symptoms marked with an N (for now) and provide similar information.

P or N	Symptom	Brief Description
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____

Client Name _____

P or N	Symptom	Brief Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY SPIRITUAL HISTORY

Attend church? ❑ Yes ❑ No
If yes, denomination _____
Level of involvement of parents _____
Level of involvement of child _____
Attitude of client toward God _____
Attitude of client toward church _____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____
_____

What are your child's areas of greatest accomplishment? _____
_____

What does your child enjoy doing most? _____
_____

What does your child dislike doing most? _____
_____

What are your child's greatest strengths? _____
_____

What are your child's weaknesses? _____
_____

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications) _____
_____
_____

Client Name _____

Operations _____

_____

Hospitalizations for illness(es) other than operations _____

_____

Head injuries _____

_____ with unconsciousness _____ without unconsciousness

Convulsions _____

_____ with fever _____ without fever

Coma _____

Meningitis or encephalitis _____

Immunization reactions _____

Persistent high fevers _____ Highest temperature ever recorded _____

Eye problems _____

Ear problems _____

Poisoning _____

PRESENT MEDICAL STATUS

Present height _____ Present weight _____

Present illness(es) for which child is being treated _____

_____

Medications child is taking on an ongoing basis _____

_____

Allergies to medication: _____

_____

Allergies to food: _____

_____

Other allergies: _____

FAMILY HISTORY—MOTHER

Age _____ Age at time of pregnancy with client _____

Number of previous pregnancies ____ Number of spontaneous abortions (miscarriages) ____

Number of induced abortions ____

Fertility problems (specify) _____

School: Highest grade completed _____

Learning problems (specify) _____ grade repeat _____

Behavior problems (specify) _____

Medical problems (specify) _____

Client Name _____

Have you or any of your blood relatives (not including client and siblings) ever had problems similar to those your child has? If so, describe. _____

_____

FAMILY HISTORY—FATHER

Age _____ Age at time of client's conception _____

Fertility problems (specify) _____

School: Highest grade completed _____
Learning problems (specify) _____ grade repeat _____
Behavior problems (specify) _____

Medical problems (specify) _____

Have you or any of your blood relatives (not including client and siblings) ever had problems similar to those your child has? If so, describe. _____

_____

SIBLINGS

	Name	Age	Medical, social, or academic problem
1.			
2.			
3.			
4.			
5.			

FAMILY EMOTIONAL/PSYCHOLOGICAL HISTORY (Include extended family members, such as aunts, uncles, cousins, grandparents, etc.):

Has the child had previous outpatient psychotherapy? ❑ Yes ❑ No
If yes, by whom and for how long? _____
Name Telephone

_____
Address

Length and frequency of treatment: _____

What was the diagnosis and outcome? _____

_____

Has any family member had outpatient psychotherapy? ❑ Yes ❑ No

If yes, what is relationship to child and why did this person seek treatment? (list all):

_____

_____

Has the child had previous inpatient treatment? ❑ Yes ❑ No

If yes, how many times? _____ How long was the longest stay? _____

_____
Name of facility Telephone

_____
Address

Client Name _____

What was the diagnosis and outcome? _____

_____

Has any family member had inpatient treatment for psychological, emotional, or substance abuse problem? ❑ Yes ❑ No

If yes, what is their relationship to the child and why did they seek treatment? _____

_____

Do any family members take medications for psychological problems? ❑ Yes ❑ No

If yes, what is their relationship to the child and what problem does the medicine treat? (list all):

_____

_____

Please describe what current stress the family is experiencing:

Inadequate housing? _____
Financial problems? _____
Divorce? _____
Recent death in family? _____
Other: _____

Do you think any of the above will interfere with treatment? _____

_____

LIST NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ANY OTHER PROFESSIONALS CONSULTED (e.g., neurologists, speech therapists, etc.):

1. _____
2. _____
3. _____
4. _____

ADDITIONAL REMARKS

Please use the remainder of this page to write any additional comments you wish to make regarding your child's difficulties.