

Journey Into Wellness Counseling Services, LLC

Child/Adolescent Biopsychosocial History

DEMOGRAPHICS/IDENTIFYING INFORMATION

Name: _____ DOB: _____ Assessment Date: _____
Address: _____ Home phone: _____ Alt: _____
Parent/Guardian: _____
Psychiatrist: _____
Primary Care Physician: _____
Referral Source: _____
Age: ____ Eye Color: ____ Hair Color: ____ Religious Preference: _____
Allergies: _____ Social Security Number of Insured _____
Insurance Co. & ID _____

Narrative of Presenting Problem: _____

Family History:

Who Live in Home with Child/Adolescent (names, age, and relationship to child/adolescent)

Any other family or living arrangements (joint custody, boarding school, detention, other)

Any other important information related to family please describe

Mental Status

Appetite: Normal for individual Abnormal for individual Recent weight loss/gain
 History of eating disorder: _____

Sleep Pattern: _____ hours per night Normal for individual Abnormal for individual
 Insomnia Hypersomnia Nightmares Sleepwalking

Suicide Potential (if not applicable put N/A)

Current Ideation: _____
Frequency of Ideation: _____ Last occurrence: _____
Current Intent: _____
Current Plan: _____
Prior attempt by _____ in year _____ Result: _____
Prior attempt by _____ in year _____ Result: _____

Family history of suicide or suicidal attempts: Yes No
Describe: _____

Violence Potential

Ideation of aggression towards another person? Yes _____ Denies
Ideation of destructiveness towards property? Yes _____ Denies
Child/Adolescent history of violence either toward them or by them

Medical/Developmental History

Current health status: Good Fair Poor
Currently receiving medical services for _____
Current medications include: _____
Any developmental concerns: _____

Mental Health Treatment History

Previous Outpatient Treatment (Provider names, length of treatment, date, outcome)

Previous Inpatient Treatment (Provider, length of treatment, date, outcome)

Family Mental Health History Significant For:

Substance Use History of Child/Adolescent (if not applicable put N/A)

Family history of substance abuse _____

History of Trauma

Abuse Physical _____
 Sexual _____
 Emotional _____

Loss Death of SO _____
 Divorce/separation _____
 Relocation/lifestyle change _____

Trauma Witness to death, murder or atrocities _____
 Natural Disaster _____
 Other _____

Educational History

Highest grade completed: _____ Placement in special classes: _____
Socialization/attendance/compliance with authority: _____

Financial Support:

Parents Other Family SSD Food stamps Child Support

Housing:

Lives with parents in their own home Lives with parents in their rented home/apartment
 Staying with friends Homeless Other _____

Legal History

Strengths & Positive Qualities:

Goals and hopes for treatment:

