

ROBERT A. LOWENSTEIN MD PC

Community Psychiatric Centers

Psychiatric Services for Children, Teens, and Adults

CHILD/ADOLESCENT BIOPSYCHOSOCIAL QUESTIONNAIRE

Name of Child/Adolescent: _____ DOB: _____ Gender: _____

Address: _____

_____ Phone: _____

Name of Person completing this Questionnaire: _____ Date: _____

Reason for referral: _____

PRESENTING PROBLEMS

Please check all that apply:

<input type="checkbox"/> Very Unhappy	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Fire Setting
<input type="checkbox"/> Irritable	<input type="checkbox"/> Stubborn	<input type="checkbox"/> Stealing
<input type="checkbox"/> Temper Outbursts	<input type="checkbox"/> Disobedient	<input type="checkbox"/> Lying
<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Infantile	<input type="checkbox"/> Sexual Trouble
<input type="checkbox"/> Daydreaming	<input type="checkbox"/> Mean To Others	<input type="checkbox"/> School Performance
<input type="checkbox"/> Fearful	<input type="checkbox"/> Destructive	<input type="checkbox"/> Truancy
<input type="checkbox"/> Clumsy	<input type="checkbox"/> Trouble With Law	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Overactive	<input type="checkbox"/> Running Away	<input type="checkbox"/> Soiled Pants
<input type="checkbox"/> Slow	<input type="checkbox"/> Self Mutilating	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Short Attention Span	<input type="checkbox"/> Head Banging	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Distractible	<input type="checkbox"/> Rocking	<input type="checkbox"/> Sickly
<input type="checkbox"/> Lacks initiative	<input type="checkbox"/> Shy	<input type="checkbox"/> Drug Use
<input type="checkbox"/> Undependable	<input type="checkbox"/> Strange behavior	<input type="checkbox"/> Alcohol Use
<input type="checkbox"/> Peer Conflict	<input type="checkbox"/> Strange thoughts	<input type="checkbox"/> Suicide Talk
<input type="checkbox"/> Sadness	<input type="checkbox"/> Obsessions or Compulsive Acts	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Fearfulness	<input type="checkbox"/> Phobias	<input type="checkbox"/> Other
<input type="checkbox"/> Communication Problems	<input type="checkbox"/> Socialization Problems	<input type="checkbox"/> Unusual Motor Behavior

Please explain:

How long have these problems occurred?

What happened that makes you see help at this time?

Problems perceived to be: _____very serious _____serious _____not serious

What are your child's strengths?

What are your strengths as a family?

What are your expectations of your child?

What changes would you like to see in your child?

What changes would you like to see in yourself?

What changes would you like to see in your family as a whole?

BIRTH FAMILY INFORMATION

<u>MOTHER</u>		<u>FATHER</u>	
Name:		Name:	
Race:		Race:	
D.O.B.	AGE:	D.O.B.	AGE:
S.S. #		S.S.#	
Religion Affiliation:		Religious Affiliation:	
Marital Status:		Marital Status:	
Level of Education:		Level of Education:	
Currently Employed: Yes No		Currently Employed: Yes No	
Occupation:		Occupation:	
Place of Employment:		Place of Employment:	
Work Phone:		Work Phone:	

If not married (or residing in the same household) which parent is the primary caretaker? -

Parental rights terminated? _____ YES _____ NO

1. If Yes, date of termination? _____

2. If Yes, who is the primary resource for the child? _____

3. If Yes, is child freed for adoption? _____ YES _____ NO

SIBLINGS

<u>NAME</u>	<u>DOB</u> <u>AGE</u>	<u>SEX</u>	<u>FULL/HALF</u>	<u>RESIDENCE</u>

Significant Others: (relatives living in the home, grandparents, or any person having regular involvement with the child):

<u>NAME</u>	<u>RELATIONSHIP TO CHILD</u>

Financial: What is the nature of the family's financial situation, primary source of income?

Spiritual: What is the significance/influence of the family's religious beliefs (is the family actively involved in church activities, are there any conditions/ restrictions based upon religious beliefs that should be noted):

Cultural: Are there any other cultural factors in terms of the family's beliefs, values, environmental influences, or ethnicity that should be considered in planning for the child and family?

DRUG, ALCOHOL AND TOBACCO ASSESSMENT

Has your child used any type of mood altering substance (cigarettes, alcohol, marijuana, cocaine, pills, huffing fumes...)

Yes No Not to my knowledge Maybe, Not Sure

If yes, what type of substance is used, how much, and how often

In your direct family, has anyone had problems (e.g. reprimanded at work, fired, increased arguments at home, domestic violence) due to substance use?

Yes No

If yes, who has the problem, what problems have surfaced (fired, domestic violence...) and what is their drug of choice: _____

Is there a history of drug or alcohol problems in the extended family? Yes No

If yes, please list the name and relationship the family member(s) has to your child, the types of substances abused, and the family problems it caused: _____

ABUSE HISTORY

In your family, has anyone been physically abused in their lifetime? _____

If yes, who was physically abused, and who did the abusing? _____

In your family, has anyone been sexually abused in their lifetime? _____

If yes, who was sexually abused, and who did the abusing? _____

In your family, has anyone been emotionally/mentally abused in their lifetime? _____

If yes, who was emotionally/mentally abused, and who did the abusing? _____

DEVELOPMENTAL HISTORY

At birth, age of:		Mother:		Father:	
Morning Sickness	None <input type="checkbox"/>	For 3 months <input type="checkbox"/>	Or longer <input type="checkbox"/>	Bleeding <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Kidney disease		<input type="checkbox"/>	Unusual emotional strain or worries		<input type="checkbox"/>
German measles		<input type="checkbox"/>	Unusual physical factors		<input type="checkbox"/>
High blood pressure		<input type="checkbox"/>	Mother felt life during pregnancy		<input type="checkbox"/>
Swelling of legs		<input type="checkbox"/>	Confined to bed		<input type="checkbox"/>
Other infections		<input type="checkbox"/>	How long:		
Convulsions		<input type="checkbox"/>	Mother smoked during pregnancy		<input type="checkbox"/>
Accidents		<input type="checkbox"/>	Drug/alcohol consumption		<input type="checkbox"/>
Required Special Medical Care during pregnancy					<input type="checkbox"/>
Total number of pregnancies:					
Other/special problems:					

Please specify details (i.e., month of pregnancy, type of treatment received, and how long condition lasted) regarding any item checked above.

BIRTH HISTORY:

Length of pregnancy/ # weeks:	Was anesthesia used at delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No	What kind?
Overdue	<input type="checkbox"/>	How late?
Length of labor		Described as easy <input type="checkbox"/>
Difficult	<input type="checkbox"/>	Birth was spontaneous <input type="checkbox"/>
Required forceps	<input type="checkbox"/>	Caesarean <input type="checkbox"/>
Infant was born head first	<input type="checkbox"/>	Breech/specify <input type="checkbox"/>
Birth weight of infant		Birth length
Was he/she yellow? <input type="checkbox"/> Yes <input type="checkbox"/> No		Infant required oxygen <input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	Other medical attention <input type="checkbox"/>
Infant had difficulty breathing	<input type="checkbox"/>	Vomited <input type="checkbox"/>
Was irritable	<input type="checkbox"/>	Was mother and infant discharged from hospital together? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not, when did infant leave hospital:	_____ Days _____ Weeks _____ Months	

ADDITIONAL INFORMATION/COMMENTS:

Was mother the main caretaker of the baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infant was breast fed <input type="checkbox"/>	Until age: _____
Bottle fed <input type="checkbox"/>	Until age: _____

How did child except weaning? (Cried, began sucking thumb, fussed, etc.) _____

Problems with:

<input type="checkbox"/> vomiting	<input type="checkbox"/> diarrhea	<input type="checkbox"/> constipation
<input type="checkbox"/> colic	<input type="checkbox"/> allergies	<input type="checkbox"/> rashes

Please give details regarding any of the above or other problems: _____

Was child:

<input type="checkbox"/> restless	<input type="checkbox"/> happy	<input type="checkbox"/> "good" baby	<input type="checkbox"/> "fussy" baby	<input type="checkbox"/> other
When did you add solid foods?		Was there a normal weight gain?		
Have there been any serious feeding disturbances during youngster's developing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, describe and specify age(s):				
Were foods omitted from diet? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes what and why?				

At what age did child first:

Develop teeth	First sit up	First crawl
Walk alone	Say first words	Begin to speak in sentences
Any problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify	
At what age did toilet training begin?	Bowel?	When complete?
Bladder?	When complete?	Any difficulties in training?

PHYSICAL HEALTH HISTORY

<u>HOSPITALIZATION OR SUREGERY</u>			
<u>DATE</u>	<u>REASON</u>	<u>DATE</u>	<u>REASON</u>

<u>DRUG ALLERGIES</u>	<u>CURRENT MEDICATIONS</u>

MEDICAL HISTORY

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> abdominal pain – chronic
<input type="checkbox"/> allergies/hayfever
<input type="checkbox"/> anemia <input type="checkbox"/> bruise easily
<input type="checkbox"/> ankles – swollen
<input type="checkbox"/> appetite – loss of
<input type="checkbox"/> arthritis/rheumatism
<input type="checkbox"/> asthma/wheezing
<input type="checkbox"/> back pain – recurrent
<input type="checkbox"/> bone fracture/joint injury
<input type="checkbox"/> bowel habits – change in
<input type="checkbox"/> bronchitis/chronic cough
<input type="checkbox"/> cancer
<input type="checkbox"/> chest pain
<input type="checkbox"/> convulsions/seizures
<input type="checkbox"/> diabetes

<input type="checkbox"/> diarrhea <input type="checkbox"/> constipation
<input type="checkbox"/> diverticulosis <input type="checkbox"/> crohn's colitis
<input type="checkbox"/> nausea/vomiting – persistent
<input type="checkbox"/> nervousness <input type="checkbox"/> depression
<input type="checkbox"/> venereal disease
<input type="checkbox"/> fatigue – chronic
<input type="checkbox"/> foot pain <input type="checkbox"/> cold numb feet

<input type="checkbox"/> other _____
<input type="checkbox"/> other _____
<input type="checkbox"/> other _____ | <input type="checkbox"/> gall bladder trouble
<input type="checkbox"/> gout
<input type="checkbox"/> hair loss
<input type="checkbox"/> headaches – frequent
<input type="checkbox"/> heart murmur/defects
<input type="checkbox"/> hemorrhoids
<input type="checkbox"/> hernia
<input type="checkbox"/> high blood pressure
<input type="checkbox"/> indigestion or heartburn
<input type="checkbox"/> infections – frequent
<input type="checkbox"/> jaundice/hepatitis
<input type="checkbox"/> kidney stones
<input type="checkbox"/> lactose intolerance
<input type="checkbox"/> leg pain – walking
<input type="checkbox"/> memory loss

<input type="checkbox"/> mental illness
<input type="checkbox"/> muscle weakness
<input type="checkbox"/> urine – blood in
<input type="checkbox"/> varicose veins/phlebitis
<input type="checkbox"/> eye infections
<input type="checkbox"/> osteoporosis | <input type="checkbox"/> pneumonia
<input type="checkbox"/> prostate disease
<input type="checkbox"/> psoriasis <input type="checkbox"/> eczema
<input type="checkbox"/> rashes <input type="checkbox"/> hives
<input type="checkbox"/> sexual/menstrual dysfunction
<input type="checkbox"/> sinus trouble
<input type="checkbox"/> stools – bloody or tarry
<input type="checkbox"/> stroke
<input type="checkbox"/> swallowing difficulty
<input type="checkbox"/> tetanus
<input type="checkbox"/> throat – sore – frequent
<input type="checkbox"/> thyroid disease
<input type="checkbox"/> tremor/hands shaking
<input type="checkbox"/> ulcers – peptic
<input type="checkbox"/> urethral discharge

<input type="checkbox"/> diphtheria
<input type="checkbox"/> dizziness/fainting
<input type="checkbox"/> ear infections – frequent
<input type="checkbox"/> ear – ringing in
<input type="checkbox"/> numbness/tingling sensations
<input type="checkbox"/> weight loss – recent | <input type="checkbox"/> chicken pox
<input type="checkbox"/> polio <input type="checkbox"/> mumps
<input type="checkbox"/> measles
<input type="checkbox"/> rubella
<input type="checkbox"/> rheumatic fever
<input type="checkbox"/> scarlet fever
<input type="checkbox"/> tuberculosis
<input type="checkbox"/> herpes
Urination -
<input type="checkbox"/> overnight – less than twice

<input type="checkbox"/> bed wetting
<input type="checkbox"/> painful <input type="checkbox"/> loss of control
<input type="checkbox"/> Sickle Cell Disease/Trait
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Bone fractures

<input type="checkbox"/> nose bleeds
<input type="checkbox"/> vision – failing |
|---|---|--|---|

FAMILY MEDICAL HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS

-
- Alcohol: Type _____
-
- Amount: _____
-
-
- Coffee: cups daily _____
-
- Other caffeine: _____
-
-
- Diet: Salt intake _____
-
- Fate intake: _____
-
- Other: _____
-
-
- Exercise Routine: _____
-
-
- Sleep: Difficulty falling asleep: _____
-
- Continuity Disturbances _____
-
- Early Morning Awakening _____
-
- Daytime Drowsiness _____
-
- Other _____
-
-
- Smoke: Packs daily _____
-
- How long _____
-
- Interested in stopping? _____

EDUCATION HISTORY

School Placement History

School	Dates or Grades	Placement Type

Has your child repeated any grades? If yes, explain:

Most recent Achievement Test: Type	Date	Results

What are your child's academic/school strengths (i.e.: favorite subjects, involvement in school activities, helpful, attentive, obeys rules, etc.):

Has your child ever been recommended for special classes? _____ If yes, explain:

Does your child currently have or ever had an IEP? _____ If yes, explain:

LEISURE AND RECREATION

What are some examples of how child likes to spend his/her time, any special interests:
Check all that apply to child:

- | | | |
|--|---|---|
| <input type="checkbox"/> Watches TV frequently | <input type="checkbox"/> Need to learn to relax | <input type="checkbox"/> Believes he/she is clumsy |
| <input type="checkbox"/> Likes to read | <input type="checkbox"/> Seldom interactive | <input type="checkbox"/> Enjoys painting/drawing |
| <input type="checkbox"/> Enjoys playing games | <input type="checkbox"/> Enjoys machines | <input type="checkbox"/> Enjoys woodworking |
| <input type="checkbox"/> Likes hiking/being outside | <input type="checkbox"/> Enjoys computers | <input type="checkbox"/> Likes to create or build |
| <input type="checkbox"/> Enjoys watching sports
(which ones?) | <input type="checkbox"/> Enjoys playing sports
(which ones?) | <input type="checkbox"/> Spends much time on Internet |

Other: _____

Does child have a best friend? _____ Yes _____ No
 Name of best friend _____
 Age of best friend _____ How often does child see best friend _____

Does child have a steady girlfriend/boyfriend? _____ Yes _____ No
 Does child date on a regular basis? _____ Yes _____ No
 Is child sexually active? _____ Yes _____ No

Has child ever been, or currently employed? _____ Yes _____ No
 If yes, what type of job, length of employment, number of hours worked per week:

