One Step at a Time Counseling Services

CHILD

BIO-PSYCHOSOCIAL ASSESSMENT

1. **Gender** _____

2. **INTAKE INFORMATION:**

History of Presenting Problem:_____

_____

_____

Previous Treatment History and/or Diagnostic History (Include diagnoses, treatment information and dates):

Mental Health _____

_____

Substance Abuse _____

_____

Domestic Violence _____

_____

3. **Do you smoke YES ☐ NO ☐**

If yes how many pack per day? _____

4. **ASSESSMENT/INTERPRETATIVE SUMMARY-CURRENT**

Client Name:_____

What assets does client have that will help him/her succeed in treatment? _____
_____
_____
_____

What are the possible barriers/roadblocks that may hinder client's progress in treatment?
_____
_____

_____

Type of treatment services needed: ☐ individual/Interactive ☐ Family
☐ Rehabilitation/Life Skills ☐ Case Management ☐ Other_____

Frequency of Services: ☐ Once weekly ☐ Twice weekly ☐ Other_____

Preferred Location of Services: ☐ Home ☐ School ☐ Other _____

List any specialized skills, therapeutic knowledge, and/or tools to be provided in order to enhance treatment outcome: _____

Are there any referral to and/or collaboration with another agency? Yes ☐ No ☐
If yes, list name and telephone number _____

Are there any co-occurring disabilities/disorders that will affect treatment? Yes ☐ No ☐
If yes, what are they? _____
If yes, how will they be addressed in treatment? _____
_____

Are there any needs for assistive technology? Yes ☐ No ☐
If yes, how will they be addressed in treatment? _____
_____

Other pertinent information: _____
_____

5. HEALTH HISTORY/CURRENT BIOMEDICAL CONDITIONS

Any current medical/health problems? ☐ Yes ☐ No

If yes, what is the diagnosis/problem(s)? _____
_____
_____

If applicable-What treatment are you receiving? _____
_____
_____

Do you have an advanced directive? ☐ Yes ☐ No
If so, how will it impact your treatment? _____
_____
_____

Any disabilities that would affect your treatment? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

Any allergies to medication? ☐ Yes ☐ No
If, yes list medications _____
_____
_____
_____

Personal physician _____

Are you currently taking prescribed or over the counter medication? ☐ Yes ☐ No
If yes, list medications below:

Medication	Physician	Strength/Dosage	Date Initiated

(List additional medications on additional pages)

Client Name:_____

How have you adjusted to treatment/medication? _____
_____
_____

What present or past medications were effective? Not effective? _____
_____
_____
_____
_____
_____

6. HISTORY OF VIOLENT BEHAVIOR/SUICIDAL TENDENCIES

Do you have a history of violent behavior? ☐ Yes ☐ No
If yes, describe and include dates _____
_____
_____
_____

Have you ever attempted suicide? ☐ Yes ☐ No
If yes, describe and include dates _____
_____

DOMESTIC VIOLENCE/SEXUAL ASSUALT

Have you ever been a victim or witnessed of emotional abuse and/or neglect ☐ Yes ☐ No
If yes, describe: _____
_____
_____

Have you ever been a victim or witnessed of domestic violence and/or neglect ☐ Yes ☐ No
If yes, describe: _____
_____
_____

Have you ever been a victim or witnessed of sexual assault and/or neglect? ☐ Yes ☐ No
If yes, describe: _____
_____
_____

Who was the perpetrator? _____
Any resolve? Please explain: _____

Client Name:_____

Have you received counseling for sexual assault/abuse? ☐ Yes ☐ No

If yes, describe: _____

How recent or how long ago? _____

Do you feel this has helped you? ☐ Yes ☐ No

7. FAMILY/MARITAL, SOCIAL HISTORY, LIVING SITUATION

Family Member/Name	Age	City/State	Current Relationship
Father			
Mother			
Sister			
Brothers			
Spouse			
Children			

With whom do you currently live? _____ Number in Home _____

Current Living Environment: _____ House _____ Apt __ Duplex _____ Other _____

Who have you lived within the past? _____

Any significant childhood losses? Include divorce, death and estrangement. _____

_____

_____

Age of loss(es) _____

Any history of alcohol/drug abuse or mental illness in family or origin? ☐ Yes ☐ No

If yes, list family members (s) _____

Have any family member been treated for any of the above? ☐ Yes ☐ No

If yes, list family member(s) _____

_____

_____

Client Name: _____

Significant other relationships: List year and length of relationship or marriage, year of separation or divorce, number of children: _____
_____
_____

Does significant other drink or use drugs? ☐ Yes ☐ No ☐ N/A

8. CULTURAL/RELIGIOUS ORIENTATION

What is your race or ethnicity? ☐ Caucasian ☐ African American ☐ Asian
☐ Hispanic ☐ Native American ☐ Other _____

How will your cultural practices affect treatment? _____
_____
_____

What is your religious background? ☐ Protestant ☐ Jewish ☐ Catholic
☐ Other ☐ None

Does client attend church on a regular basis? ☐ Yes ☐ No

Spiritual beliefs and practice of same? _____

Are you a U.S. citizen? ☐ Yes ☐ No
If no, how long have you been in the U.S.? _____

9. OCCUPATIONAL/MILITARY HISTORY (clients 16 years +) N/A ☐

Employer _____ Job Title _____
Employer's address _____ How long employed? _____
Employer's phone number _____How long employed? _____
Other sources of income (ie.e. SSI, disability, VA, retirement, child support, etc):
_____
_____
_____

Previous employment:

Employer Dates Title Reason for leaving

_____

_____

_____

What types of work are you qualified to perform? _____

_____

_____

Have you ever been in the military? ☐ Yes ☐ No

If yes, what branch, dates of service and type of discharge. _____

_____

_____

10.SEXUAL HISTORY

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No

If yes, what form(s) of protection and/or birth control do you use? _____

_____

_____

Are you currently sexually active? ☐ Yes ☐ No

If yes, details of what, when, etc. _____

_____

_____

Do you desire help obtaining services for infection screening? ☐ Yes ☐ No

If yes, note counselor's report of action taken to assure the request services: _____

_____

_____

Sexual orientation: _____

11.RECREATIONAL/LEISURE HISTORY

What do you currently like to do for recreation? _____

How have spent your leisure time in the past? _____

Client Name:_____

12. **LEGAL HISTORY**

What is your legal status? _____

List chronologically any past convictions:

Offense	Felony/Misdemeanor	Age	Sentence	Jail Time

13.ECONOMIC RESOURCES (adult clients) N/A ☐

Do you own a home? ☐ Yes ☐ No Do you rent a home? ☐ Yes ☐ No
Do you own a car? ☐ Yes ☐ No

How do you currently support yourself and your family financially? _____
_____
_____

14.CURRENT SUPPORT SYSTEM

To whom do you currently look for support? _____
_____
_____

Do they support your entering treatment? ☐ Yes ☐ No

Are you experiencing severe isolation or withdrawal from social contact? ☐ Yes ☐ No
If yes, explain: _____
_____
_____
_____

15.CLIENT'S QUALITIES (client responses needed)

What are your strengths/abilities? (assets, resources, natural positives) _____

Client Name:_____

_____
_____
_____

What are your needs/interests? (weakness, what do you need to recover) _____
_____
_____
_____

What are abilities/interests? (skills, aptitudes, capabilities talents, competencies) _____
_____
_____
_____

What are your preferences? (what will enhance treatment experience)? _____
_____
_____
_____

What do you expect from this program in terms of service? _____
_____
_____
_____

BIOPSYCHOSOCIAL ADDENDUM
CHILDREN AND ADOLESCENTS

16. EDUCATION & SCHOOL HISTORY

Are you currently enrolled in school? ☐ Yes ☐ No

Present school attending/will attend _____ Grade level _____

Do you have an IEP or a 504 Plan? ☐ Yes ☐ No ☐ N/A
If so, please explain._____

Have you had to repeat a grade? ☐ Yes ☐ No
If yes, what grade? _____

Client Name:_____

Have you ever been placed in special education classes or a resource room? ☐ Yes ☐ No
If yes, explain: _____
_____
_____

Can you read and write? ☐ Yes ☐ No

Have you been diagnosed with a learning disability? ☐ Yes ☐ No

Do you have difficulty reading? ☐ Yes ☐ No

Do you have difficulty writing? ☐ Yes ☐ No

How are your grades now? _____
_____
_____

Have you failed any classes in the past? ☐ Yes ☐ No

Has your school performance changed? ☐ Yes ☐ No
If yes, explain: _____
_____
_____

Have you been suspended or expelled? ☐ Yes ☐ No
If yes, explain: _____
_____
_____

How many days of school did you miss, the last semester you attended? _____

List specialized training, if any _____

Have you attended a vocational school or college? ☐ Yes ☐ No
If yes, which one? _____

17.DEVELOPMENTAL HISTORY

Any problems at birth? _____
_____
_____

Prenatal exposure to any alcohol, tobacco, or other drugs? ☐ Yes ☐ No
If yes, explain: _____
_____
_____

Source of information:_____

Age first walked? _____ Age first talked? _____

Known developmental delays:_____

Any problems hearing? ☐ Yes ☐ No Has this been tested? ☐ Yes ☐ No

Any vision problems? ☐ Yes ☐ No Has this been tested? ☐ Yes ☐ No

Do you have problems with speech? ☐ Yes ☐ No

Do you have any speech therapy? ☐ Yes ☐ No

18.FAMILY HISTORY/PLACEMENTS

Current legal custody or legal guardianship (may not be the same as current physical custody)
☐ Mother ☐ Father ☐ Joint ☐ DHS ☐ Other

With whom have you lived and at what ages? _____

Note psychological problems of parents and other caretaker (list who and what:_____
_____
_____

19.IMMUNIZATIONS

Are immunizations currently up to date ☐ Yes ☐ No

Client Name:_____

Source of information _____

20.PEER INTERACTIONS

Who are you friends? _____

What do you like to do together? _____

Do any of them drink or use drugs? ☐ Yes ☐ No

Any problems with peers? ☐ Yes ☐ No
Comments: _____
_____
_____
_____

_____ _____
Therapist's signature/credentials Date

Client Name:_____