

Empower Wellness
BIOPSYCHOSOCIAL CHILD ASSESSMENT

Please use Blue or Black Ink Only

Demographics

Client Name:		Date:
Current Address: City/State: Zip Code:		Phone #:
Date of Birth:	Marital/Relationship Status:	
Ethnicity:		
Primary Language Spoken:		Secondary Language:
Referral Source:		Phone:
Emergency Contact:		Phone:

Family Relationships

Does the client have any children?					
Name	Date of Birth	Sex	Custody? Yes or No	Lives With?	Additional Information
Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)					
Name	Age	Sex	Relationship	Additional Information	
Primary Language of household/family:			Secondary Language:		

Family History

Family History of (select all that apply):						
	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol/Substance Abuse:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Completed Suicide:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Mental Illness/Problems Such as:						
Alzheimer's Disease/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention-Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incarceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:						

Client's/Family's Presentation of the Problem:

Client's/Family's Expected Outcome:

Physical Functioning

Allergies (Medication & Other):

Current Medical Conditions:

Surgeries:

Current Medications (include vitamins, herbs, and over-the-counter):

Past Medications:

Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including residential treatment centers, group homes, therapeutic foster care, aftercare, inpatient psychiatric hospitalizations, and outpatient medication treatment/therapy):

Dates:	Inpatient/Outpatient	Location	Reason	Completed? Y/N

Pain Questionnaire

Pain Management: Are you currently in pain now? YES NO
 If yes, please state location of your pain and rate your pain on a scale of 1-10 (with 10 being the most severe) and write your score here:

Are you currently receiving care for the pain? YES NO
 If no, would you like a referral for pain management? YES NO

Nutrition

Appetite: GOOD FAIR POOR Select all that apply:

<input type="checkbox"/> Recently gained/lost significant weight	<input type="checkbox"/> Binges/overeats to excess
<input type="checkbox"/> Restricts food/Vomits/over-exercises to avoid weight gain	<input type="checkbox"/> Special dietary needs
<input type="checkbox"/> Hiding/Hoarding Food	<input type="checkbox"/> Food allergies

Comments:

During pregnancy, did your mother or if child (you) use any of the following (select all that apply)?

<input type="checkbox"/> TOBACCO	<input type="checkbox"/> ALCOHOL	<input type="checkbox"/> STREET DRUGS	<input type="checkbox"/> UNKNOWN
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Comments (frequency and intensity of use, participation in treatment, birth defects or malformations due to drug/alcohol use among siblings?)

Any problems labor and/or delivery? Apgar Scores?

Developmental Milestones- please select any that were done late or if patient is child, is still having trouble with:		
<input type="checkbox"/> Rolling Over (2-6 months)	<input type="checkbox"/> Sitting (6-12 months)	<input type="checkbox"/> Standing (8-16 months)
<input type="checkbox"/> Walking (8-16 months)	<input type="checkbox"/> Engaging peers (24-36 months)	<input type="checkbox"/> Toileting (24-36 months)
<input type="checkbox"/> Dressing self (24-36 months)	<input type="checkbox"/> Feeding self	<input type="checkbox"/> Sleeping alone
<input type="checkbox"/> Tolerating Separation	<input type="checkbox"/> Playing cooperatively	<input type="checkbox"/> Speaking
Are immunizations up to date? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Has the client had any of the following (select all that apply)?		
Blood Disorder:	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising
Brain Disorders:	<input type="checkbox"/> Confusion	<input type="checkbox"/> Headaches <input type="checkbox"/> Coordination Problems
	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Staring <input type="checkbox"/> Tremors
	<input type="checkbox"/> Tic (motor/vocal)	<input type="checkbox"/> Head Injuries <input type="checkbox"/> Seizures Last seizure:
GI Problems:	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Incontinence <input type="checkbox"/> Vomiting
Heart/Lung Problems:	<input type="checkbox"/> Asthma <input type="checkbox"/> Chest Pain <input type="checkbox"/> Murmur <input type="checkbox"/> Surgery	<input type="checkbox"/> Congenital Heart Disease
Hormone Problems:	<input type="checkbox"/> Obesity <input type="checkbox"/> Thyroid	<input type="checkbox"/> Early Puberty <input type="checkbox"/> Late Puberty
Infections:	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles	<input type="checkbox"/> Sinus Infections
<input type="checkbox"/> Covid-19 Infections	<input type="checkbox"/> Meningitis <input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Encephalitis
<input type="checkbox"/> Mumps	<input type="checkbox"/> High Fevers <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Covid-19 <input type="checkbox"/> Other
Injuries:	<input type="checkbox"/> Broken Bones <input type="checkbox"/> Stitches	<input type="checkbox"/> Other
Kidney Problems:	<input type="checkbox"/> Bed Wetting <input type="checkbox"/> Daytime Wetting	<input type="checkbox"/> Infections
Muscle/Bone Problems:	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Spasticity	<input type="checkbox"/> Other:
Poisoning:	<input type="checkbox"/> Chemicals <input type="checkbox"/> Lead	<input type="checkbox"/> Other
Sensory Problems:	<input type="checkbox"/> Hearing <input type="checkbox"/> Tactile (feeling)	<input type="checkbox"/> Vision
Sexual Problems:	<input type="checkbox"/> Birth Control <input type="checkbox"/> Masturbation	<input type="checkbox"/> Promiscuity <input type="checkbox"/> Erectile Dysfunction
Skin Disorders:	<input type="checkbox"/> Acne <input type="checkbox"/> Birthmarks	<input type="checkbox"/> Eczema <input type="checkbox"/> Hair Loss

Social

Supportive Social Network? (Rate the network using a scale of 1 Weak to 5 Strong)			
Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	
Living Situation:			
<input type="checkbox"/> Housing Adequate	<input type="checkbox"/> Housing Dangerous	<input type="checkbox"/> Housing Overcrowded	<input type="checkbox"/> Homeless
<input type="checkbox"/> Dependent Upon Others	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Ward of State/Tribal Court	
Additional Information:			
Employment: Are you currently employed?			
YES	Employer:	Length of Employment:	
	<input type="checkbox"/> Satisfied <input type="checkbox"/> Not Satisfied	<input type="checkbox"/> Supervisor Conflict	<input type="checkbox"/> Co-worker Conflict
NO	Last Employer:	Reason for Leaving:	
	<input type="checkbox"/> Never Employed <input type="checkbox"/> Disabled	<input type="checkbox"/> Student	<input type="checkbox"/> Unstable Work History
Family Financial Situation:			
<input type="checkbox"/> No Current Problems	<input type="checkbox"/> Large Indebtedness	<input type="checkbox"/> Relationship Conflicts Over Finances	
<input type="checkbox"/> Impulsive Spending	<input type="checkbox"/> Poverty of Below	<input type="checkbox"/> Financial Difficulties	

Legal Status Screening

Past or current legal problems (select all that apply)		
<input type="checkbox"/> None	<input type="checkbox"/> Parole	<input type="checkbox"/> Probation
<input type="checkbox"/> Arrests	<input type="checkbox"/> Conviction	<input type="checkbox"/> DUI/DWI
<input type="checkbox"/> Jail	<input type="checkbox"/> Prison	<input type="checkbox"/> Detention Center
<input type="checkbox"/> Gangs	<input type="checkbox"/> Other	
If yes to any of the above, please explain: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Any court-ordered treatment? Please explain below.		
Ordered By	Offense	Length of Time

Child/Adolescent Educational Assessment

<input type="checkbox"/> Public	<input type="checkbox"/> Tribal	<input type="checkbox"/> Boarding: Starting age	<input type="checkbox"/> Charter
<input type="checkbox"/> Private	<input type="checkbox"/> Home	<input type="checkbox"/> Alternative	<input type="checkbox"/> GED
<input type="checkbox"/> Technical College	<input type="checkbox"/> College	<input type="checkbox"/> Other:	
Current grade level:	Skipped a grade:	Held back a grade:	
Any testing for an IEP (Individualized Education Plan)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
History of/or current placement in special education? <input type="checkbox"/> YES <input type="checkbox"/> NO How many hours per day? ___ hrs.			
For learning problems? <input type="checkbox"/> YES <input type="checkbox"/> NO For behavior problems? <input type="checkbox"/> YES <input type="checkbox"/> NO			
History of hyperactivity at school? <input type="checkbox"/> YES <input type="checkbox"/> NO Comments:			
Ever been expelled or suspended? <input type="checkbox"/> YES <input type="checkbox"/> NO Reason:			
School attendance problems? <input type="checkbox"/> YES <input type="checkbox"/> NO Comments:			
Other education-related concerns:			

Leisure & Recreation

Which of the following does the client do? (Select all that apply).	
<input type="checkbox"/> Spend time with friends	<input type="checkbox"/> Sports/exercises
<input type="checkbox"/> Classes	<input type="checkbox"/> Dancing
<input type="checkbox"/> Spending time with family	<input type="checkbox"/> Hobbies
<input type="checkbox"/> Work part-time	<input type="checkbox"/> Watch movies/television
<input type="checkbox"/> Go "downtown"	<input type="checkbox"/> Stay at home
<input type="checkbox"/> Listen to music	Other:
What limits the client's leisure/recreational activities?	

Functional Assessment

Is client able to care for him/herself? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain:			
Uses or needs assistive or adaptive device (Select all that apply)			
<input type="checkbox"/> None	<input type="checkbox"/> Glasses	<input type="checkbox"/> Walker	<input type="checkbox"/> Braille
<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Translated Written Information	<input type="checkbox"/> Translator for Speaking	<input type="checkbox"/> Other:	

Psychological

History of Depressed Mood? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, were you professionally diagnosed by a psychiatrist and when?			
If no, what time period were you depressed?			
History of irritability, anger, or violence (tantrums, hurt others, cruelty to animals, destroy property):			
Sleep Pattern: Number of hours per day Time to onset of sleep falling asleep # of awakenings?			
<input type="checkbox"/> Normal	<input type="checkbox"/> Sleeping too much	<input type="checkbox"/> Sleeping too little	
Energy Level: <input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High			
History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal?) Select all that apply:			
<input type="checkbox"/> Intrusive memories, thoughts, perceptions	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Flashbacks	
<input type="checkbox"/> Avoiding thoughts, feelings, conversations	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Irritability	
<input type="checkbox"/> Hypervigilance	<input type="checkbox"/> Other:		
Any additional information:			
Bereavement/Loss and Spiritual Awareness			
Please list significant losses, deaths, abandonments, traumatic incidents:			

Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, abandonments, traumatic incidents: If yes, please explain.			
Has client been abused at any time in the past or present by family, significant others, or anyone else?			
<input type="checkbox"/> NO <input type="checkbox"/> YES, Explain:			
Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal putdowns			<input type="checkbox"/> YES <input type="checkbox"/> NO
Being threatened			<input type="checkbox"/> YES <input type="checkbox"/> NO
Made to feel afraid			<input type="checkbox"/> YES <input type="checkbox"/> NO
Pushed			<input type="checkbox"/> YES <input type="checkbox"/> NO
Shoved			<input type="checkbox"/> YES <input type="checkbox"/> NO
Slapped			<input type="checkbox"/> YES <input type="checkbox"/> NO
Kicked			<input type="checkbox"/> YES <input type="checkbox"/> NO
Strangled			<input type="checkbox"/> YES <input type="checkbox"/> NO
Hit			<input type="checkbox"/> YES <input type="checkbox"/> NO
Forced or coerced into sexual activity			<input type="checkbox"/> YES <input type="checkbox"/> NO
Other			<input type="checkbox"/> YES <input type="checkbox"/> NO
Was it reported? <input type="checkbox"/> YES <input type="checkbox"/> NO To whom?			
Has client ever witnessed abuse or family violence? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:			

Behavioral Assessment

Abuse/Addiction- Chemical and Behavioral				
DRUG	Age First Used	Age Heaviest Use	Recent Pattern of Use (frequency, amount, how used)	Date Last Used
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, speed, amphetamines, etc.)				
Methamphetamines				
Inhalants (gas, paint, glue, whips, etc.)				
Hallucinogens, LSD, PCP, mushrooms, etc.				
Opioids (narcotics, heroin, methadone, suboxone, etc.)				
Sedative/Hypnotics (Valium, Xanax, Phenobarb., etc.)				
Designer Drugs/Other (herbal, steroids, cough syrup, Kratom, etc.)				
Tobacco (smoke, chew, vape)				
Caffeine				
Ever injected drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, which ones?				
Drug of choice?				
Consequences as a Result of Drug/Alcohol Use (select all that apply)				
<input type="checkbox"/> Hangovers	<input type="checkbox"/> DTs/Shakes	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Binges	
<input type="checkbox"/> Overdoses	<input type="checkbox"/> Increased Tolerance (need more to get high)	<input type="checkbox"/> Gastrointestinal Bleeds	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Relationship Problems	<input type="checkbox"/> Quit School	
<input type="checkbox"/> Lost Job	<input type="checkbox"/> DUI/DWI's	<input type="checkbox"/> Assaults	<input type="checkbox"/> Arrests	
<input type="checkbox"/> Incarcerations	<input type="checkbox"/> Homicide	<input type="checkbox"/> Other:		
Longest Sober Period of Sobriety?		How long ago?		
Triggers to use (list all that apply):				
Have you traded sex for drugs? <input type="checkbox"/> NO <input type="checkbox"/> YES, explain:				
Have you been tested for HIV? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, date of last test: Results:				
Risk Taking/Impulsive Behaviors (current/past) – select all that apply:				
<input type="checkbox"/> Unprotected sex	<input type="checkbox"/> Shoplifting	<input type="checkbox"/> Reckless driving		
<input type="checkbox"/> Gang Involvement	<input type="checkbox"/> Drug Dealing	<input type="checkbox"/> Carrying/using weapon		
<input type="checkbox"/> Other:				