

**Sand Castle Counseling**  
1890 N. Market St.  
Elizabethtown, PA 17022  
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**Child/Adolescent Biopsychosocial Assessment**

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Child's Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Form completed by: \_\_\_\_\_

**Presenting Problem**

What are the main concerns that bring you to therapy?

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How long has this been a concern? \_\_\_\_\_

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What have you already tried to address the problem? \_\_\_\_\_

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What do you hope to get from therapy and what are your goals for therapy?

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Here is a list of common symptoms – please feel free to circle those that concern you about your child.

Depression/Sadness	Withdrawn	Low Self Esteem	Loss of Interests
Self Injurious Behaviors	Poor Sleep Patterns/Nightmares	Poor Social Skills	Defiant/Uncooperative
Anger Problems	Aggression Towards Others	Drug/Alcohol Use	Over Sexualized Behaviors
Poor Self Control	Destruction of Property	Hyperactivity	Inattentive/Poor Focus
Excessive Fears/Worry	Bedwetting or Encopresis/Enuresis	Hallucinations/Delusions Or Dissociations	Regressive Traits/ Immature for Age
Physical Symptoms	Lying	Change in Grades	Change in Appetite

Traumatic childhood events such as abuse, neglect, and witnessing experiences like crime, parental conflict, mental illness, and substance abuse can result in long-term negative effects on learning, behavior and health (from the ACES study).

Sudden loss of a family member or pet	Frequent moving	Planned or unplanned time away from child	Parental conflict/divorce
Witness to community violence	Natural disasters	Witness to domestic violence	Someone who is chronically medically ill
Someone who is chronically depressed or suicidal living in the household	Alcohol or drug abuser in the household	Incarcerated family member	Life threatening events or accidents
Physical abuse	Emotional Abuse/Neglect	Sexual abuse	Military deployment

Additional information about circled concerns: \_\_\_\_\_

\_\_\_\_\_

### **Risk Assessment**

<b>Risk Assessment</b>	<b>Yes/No</b>	<b>Explain</b>
Has your child ever made suicidal statements or made suicide attempts?		

Has your child ever intentionally harmed an animal/pet?		
Has your child ever engaged in self-harming behavior?		
Do you have concerns that your child may be using drugs or alcohol?		

**Past Counseling/Therapeutic Services**

<b>Dates received/attended</b>	<b>Provider/Agency</b>	<b>Phone/Address</b>	<b>Diagnosis (if assigned)</b>

Has anyone in your family or extended family ever had psychotherapy or counseling before?

Yes/No \_\_\_\_\_  
 \_\_\_\_\_

**Family Information**

Please list family members that live in the home with child (and pets):

<b>Name</b>	<b>Relationship</b>	<b>Age</b>	<b>Describe their relationship with child.</b>

Other immediate family members that live outside of the home (i.e., parents or siblings):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Primary caregivers' relationship status. Please circle:

- Married
- Single
- Partnered
- Separated
- Divorced

Are there family members or others that you consider part of your family's support system?

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History of CPS or alternate placements (kinship, foster, group home)? Yes/No Please describe.

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Does your family actively participate in religion/spirituality? Yes/No (If yes, where?) Is your child involved in the youth program? \_\_\_\_\_

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### Medical History

Primary Care Doctor or Pediatrician (Name/Address/Phone Number): \_\_\_\_\_

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Please list any medications your child is taking at this time:

Name of medication	Dosage	Reason for taking	Prescribing Physician

Is your child up to date on their vaccinations? \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Has your child ever been bitten by a tick?

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Any history of head injuries/allergies/surgeries? \_\_\_\_\_

Please describe any past and present medical concerns or serious illnesses: \_\_\_\_\_

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Are you aware of any sensory processing issues that your child has? Yes/No (Please describe.)

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Are there any extended family members who have been diagnosed with a mental health disorder? Identify family member's relationship to your child and the medical condition:

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Is there any family use of alcohol or drugs? Yes/No (Please describe).

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### **Developmental History**

Were kids always a part of your life plan? \_\_\_\_\_

How many total pregnancies have you had? \_\_\_\_\_

Any history of infertility, miscarriages, and/or stillborn losses? \_\_\_\_\_

Term of pregnancy: \_\_\_\_\_ months Birth weight: \_\_\_\_\_

Were there any complications with the pregnancy or delivery? (i.e., time spent in the NICU? Ongoing medical issues as a result?) Yes/No (Please describe.) \_\_\_\_\_

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During pregnancy, was there any use of drugs/alcohol, exposure to domestic violence, major illnesses/accidents, or significant stressors? Yes/No (Please describe.) \_\_\_\_\_

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Please list approximate ages when child reached the following milestones:

Speaking	
Walking	
Potty Trained	

Any problems with feeding or sleeping? Yes/No (Please describe) \_\_\_\_\_

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	Concerns regarding development or peers?	Significant stressors?	Temperament of child?	Peer/teacher relations?
<b>Ages 0-3</b>				
<b>Ages 4-6</b>				
<b>Ages 7-12</b>				
<b>Ages 13-18</b>				

What technology/social media does your child have current access to? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How is technology monitored in the home? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any issues of bullying either online or in school? (communicating with strangers, etc)

\_\_\_\_\_

\_\_\_\_\_

### **School Information**

Current school and grade: \_\_\_\_\_

What schools has your child attended in the past? \_\_\_\_\_

\_\_\_\_\_

Has your child been identified as having a learning disorder? Any accommodations for learning?  
Yes/No (IEP, 504, OT/PT, speech)

\_\_\_\_\_

\_\_\_\_\_

Has your child ever received speech therapy or occupational therapy? Yes/No (If yes, please describe.) \_\_\_\_\_  
 \_\_\_\_\_

Do you have concerns about your child's behavior at school? \_\_\_\_\_  
 \_\_\_\_\_

What activities or clubs is your child involved in? \_\_\_\_\_  
 \_\_\_\_\_

### **Child Management**

What methods do you generally use for discipline of your children? Circle:

Time out \_\_\_\_\_      Discuss with child \_\_\_\_\_      Lecture \_\_\_\_\_      Remove privileges \_\_\_\_\_  
 Add chores \_\_\_\_\_      Spank \_\_\_\_\_      Send to room (alone) \_\_\_\_\_

Are you consistent with your discipline? Yes/No (If no, please describe.) \_\_\_\_\_  
 \_\_\_\_\_

How does your child typically respond when disciplined? \_\_\_\_\_  
 \_\_\_\_\_

What do you consider to be your family strengths? What do you feel that you need to improve or change as a family? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### **Additional Information**

What are some of the strengths and positive qualities of your child? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there any other information that I should know regarding your child or family? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_