Patient Name: ____________________________

Biopsychosocial History & Assessment
Adolescent Self-Report (Part A)

Instructions: In order to assist your therapist and the treatment team in better understanding you and your situation, teens 14 years and older are to complete the following questions themselves, with the assistance of their parents, if necessary.

Name: ____ Age: _______ Date of Birth: ____________________

Race/ethnicity: ____

Gender identity*: ____

Preferred pronouns: ____
(e.g., she/her/hers; he/him/his; ze, zer, zirs)

Sexual orientation*: ____

* Leave blank if you prefer not to answer.

Check if you are experiencing problems in any of the following areas:

- ☐ Mood (e.g., depression, anxiety)
- ☐ Anger management
- ☐ Stress management
- ☐ Impulsivity
- ☐ Hyperactivity
- ☐ School/ grades
- ☐ Family relationships
- ☐ Friend/peer relationships
- ☐ Sexual health/relationships
- ☐ Legal system/ law enforcement
- ☐ Physical health
- ☐ Eating habits
- ☐ Body image
- ☐ Sleep
- ☐ Fatigue/tiredness
- ☐ Other: ____

We would appreciate learning more about you and your perspective on your life. Please describe why you checked the above items and what those items mean for you:

____

____

____

____

____

____

____

____

____

What goals would you like to accomplish in treatment?

1. ____
   ____
2. ____
   ____
3. ____
   ____

Patient Name: ____________________________

4. ____

____

PSYCHOLOGICAL & MEDICAL HISTORY

Have you ever received a mental health/psychological diagnosis/es? Yes No

If yes, what was it/were they? ____

____

____

Have you ever received mental health treatment (e.g., therapy, inpatient stay)? Yes No

If yes, what was helpful? ____

____

____

…what was not or less helpful? ____

____

____

Please describe your strengths: ____

____

____

____

Please describe your family's strengths: ____

____

____

____

Please describe any physical health concerns/problems that you would like your treatment team to know about:

____

____

____

____

Below is a list of experiences that teens may experience. Please check any/all that apply to you:

- ☐ Teasing or bullying by another
- ☐ Family conflict
- ☐ Separation from parents
- ☐ Frequent moves in location
- ☐ Parental divorce
- ☐ Medical procedure or emergency
- ☐ Death or loss of someone close
- ☐ Medical problem of a parent/family member
- ☐ Emotional problem/mental illness in the home
- ☐ Family member victim of a crime
- ☐ Family member incarcerated
- ☐ Substance use in the home
- ☐ Foster care placement
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional or verbal abuse
- ☐ Witnessing violence at home
- ☐ Witnessing violence in the community
- ☐ Natural disasters
- ☐ Car crash or other serious accident
- ☐ Child victim of a crime
- ☐ Physical/emotional neglect
- ☐ Other event(s) that significantly upset you (briefly describe what happened):

Patient Name: ______________________________

SCHOOL AND SOCIAL HISTORY

How are you doing academically in school (e.g., grades)? ____

____

____

____

How is your behavior in school (e.g., following rules, being on time, absences, truancy)? ___________________

____

____

____

What extracurricular activities are you involved in (e.g., clubs, sports)? ______________________________

____

____

____

What are your hobbies/interests outside of school? ____

____

____

____

Please describe any cultural, spiritual, and/or religious beliefs/practices that you would like your treatment team to know about: ____

____

____

____

Who do you look to/rely on for support? ____

____

____

____

Do you have any problems/concerns about your friends/peers? Yes No
If yes, please describe: ____

____

____

____

Are you currently in a romantic relationship? Yes No

Are you currently sexually active? Yes No Prefer not to answer

Patient Name: ______________________________

Do you have a job? Yes No

If yes, what was it? ____

How many hours do your work a week? ________________________

Have you ever been fired from a job? Yes No

If yes, what happened? ____

____

Please circle the number that represents how frequently you use any of the following substances:

	Never	In Past	Monthly	Weekly	Daily
Caffeine: coffee, energy drinks, caffeinated tea	0	1	2	3	4
Nicotine: cigarettes, cigars, e-cigarettes, vape, juul	0	1	2	3	4
Alcohol: beer, wine, liquor	0	1	2	3	4
Marijuana: weed, hash, pot	0	1	2	3	4
MDMA, molly, ecstasy	0	1	2	3	4
Cocaine, crack	0	1	2	3	4
Stimulants: amphetamines, Adderall, Ritalin, speed	0	1	2	3	4
Opioids: pain pills, heroin, codeine, morphine, oxycodone	0	1	2	3	4
Psychedelics/Hallucinogens: LSD, acid, PCP, DXM, cough syrup, peyote	0	1	2	3	4
Sedatives: sleeping pills, Valium, Xanax, barbiturates	0	1	2	3	4
Inhalants/Solvents: glue, toluene, gasoline, whip-its	0	1	2	3	4
Other:	0	1	2	3	4

Have you had contact with law enforcement? Yes No Prefer not to answer

If yes, please describe: ____

____

____

Have you been arrested for and/or convicted of a crime? Yes No Prefer not to answer

If yes, please describe: ____

____

____

Do you have any questions for the treatment team at this time? Yes No

If yes, please describe: ____

____

____

____

Thank you!

Teen Signature: ________________________________ Date: ________________