Center for Behavioral Medicine

Patient Name: _____

Biopsychosocial History & Assessment
Parent Report (Part C)

Please provide the following information to help us understand your teen's living situation:

Teen's last name: _____ First:_____ MI: _____

Date of Birth: _____ Age: _____ Gender: _____

Primary Address: _____City: _____ Zip:_____

Primary language(s) spoken in the home: _____

Teen's home phone: _____ Teen's cell phone: _____

Caregiver 1 name: _____ Age:_____

Address: (same as above) OR:_____ City:_____ Zip:_____

Home phone: _____ Cell phone:_____ Work phone:_____

Relationship to teen (circle): Biological parent Step-parent Grandparent Foster Parent Aunt/uncle Sibling Other:_____

Relationship status (circle): Single Married Separated Divorced Widowed Other

Caregiver has (circle all that apply): Primary Custody Joint Custody Primary Placement Shared placement Other

Caregiver 2 name: _____ Age:_____

Address: (same as above) OR: _____ City:_____ Zip:_____

Home phone: _____ Cell phone:_____ Work phone:_____

Relationship to teen (circle): Biological parent Step-parent Grandparent Foster Parent Aunt/uncle Sibling Other:_____

Relationship status (circle): Single Married Separated Divorced Widowed Other

Caregiver has (circle all that apply): Primary Custody Joint Custody Primary Placement Shared Placement Other

Other Caregivers:

Instructions: In order to assist the treatment team in better understanding your teen and your family's situation, please complete the following questions. Please print neatly.

NAME OF PERSON COMPLETING FORM: **RELATIONSHIP TO TEEN:**

_____ _____

PSYCHOLOGICAL FUNCTIONING & HISTORY

What problem(s) is/are your teen having that concern(s) you?

_____
_____
_____
_____

When did the problem(s) start?

_____
_____
_____

Describe your teen's strengths:

_____
_____
_____

What would you like to see change for your teen as a result of treatment? For yourself as a caregiver?

_____
_____
_____
_____
_____
_____

Why are you and your family interested in Dialectical Behavior Therapy for Adolescents (DBT-A) at this time?

_____
_____
_____
_____

How did you learn about our clinic/program?

_____
_____
_____

Has your teen ever been in outpatient counseling or psychotherapy? Yes No

If yes, where, when, and approximately how long: _____

_____

_____

_____

Has your teen ever been in day treatment, partial hospital, or intensive outpatient counseling or psychotherapy? Yes No

If yes, where, when, and approximately how long: _____

_____

_____

_____

Has your teen had any past hospitalizations for emotional/behavioral problems? Yes No

If yes, when where, and approximately how long: _____

_____

_____

_____

Has your teen intentionally hurt themselves or made a suicide attempt? Yes No

If yes, explain when and how: _____

_____

_____

_____

If applicable, and to the best of your knowledge, what past mental health/psychological diagnosis/es has your teen received?

_____

_____

_____

Has your teen ever taken medication for emotional or behavioral concerns? Yes No

Please list medications prescribed for emotional/behavioral concerns:

Name of medication	Reason	Dosage/Frequency	Month/Year Started	Prescriber

MEDICAL HISTORY

Current medical problems or concerns: _____
_____
_____
_____

History of medical problems: _____
_____
_____
_____

Significant hospitalizations, operations, procedures or injuries: _____
_____
_____
_____

Name of primary care physician: _____ Phone: (_____)_____-_____

Last primary care visit (month and year): _____

Name of psychiatrist: _____ Phone: (_____)_____-_____

Last psychiatrist appointment (month and year): _____

Please list any prescribed medications NOT for emotional/behavioral concerns:

Name of medication	Reason	Dosage/Frequency	Month/Year Started	Prescriber

Please indicate any herbal or homeopathic substances your teen is currently taking:

FAMILY HISTORY

Please list immediate family members and other important people/relatives in your teen's life:

Name (First & Last)	Relationship to Teen	Age	School/Occupation

Who currently lives in your household? _____

_____

_____

What are your family's strengths? _____

_____

_____

Who does your teen look to for support? _____

_____

_____

Who do you as a caregiver rely on for support? _____

_____

_____

Please list family members who have experienced emotional/behavioral conditions (e.g., depression, anxiety, substance use, ADHD, learning disorders):

Relationship to Teen	Emotional/Behavioral Condition(s)

DEVELOPMENTAL HISTORY

Please answer the following questions regarding the pregnancy and delivery with this teen:

Pregnancy
- ☐ Healthy pregnancy
- ☐ Health complications during pregnancy
- ☐ Mother used tobacco/alcohol/substances during pregnancy
- ☐ Violence towards mother during pregnancy

Delivery
- ☐ Full-term
- ☐ Premature at _____ months
- ☐ Adopted at _____ months/years
- ☐ Medical complications: _____
- ☐ Congenital complications: _____
- ☐ Extended hospital stay for infant
- ☐ Extended hospital stay for mother

Where was your teen born? _____

Please indicate when your teen met the following developmental milestones:

	On time	Delayed	
Crawling	☐	☐	Age achieved: _____
Walking	☐	☐	Age achieved: _____
Talking	☐	☐	Age achieved: _____
Toilet training	☐	☐	Age achieved: _____

Please indicate if your teen experienced any of the following concerns/difficulties:

- ☐ Not liking to be touched/held
- ☐ Bedwetting/soiling after toilet training
- ☐ Difficulty with sleeping
- ☐ Difficulty with eating
- ☐ Easily upset/hard to calm down
- ☐ Not liking to be around others
- ☐ Significantly more active than peers
- ☐ Significantly less active than peers

Did your teen receive early intervention services (e.g., birth-to-three services)? Yes No

If yes, please describe: _____

_____

_____

_____

Did your teen experience any other social, emotional, cognitive, or physical developmental difficulties? Yes No

If yes, please describe: _____

_____

_____

_____

SCHOOL AND SOCIAL HISTORY

Current school: _____

City: _____ Grade: _____

Does your teen currently have an IEP? Yes No

If yes, please indicate identified impairment(s)/disability(ies):

- ☐ Speech or language impairment
- ☐ Visual impairment/Blindness
- ☐ Hearing impairment/Deafness
- ☐ Intellectual disability
- ☐ Orthopedic impairment
- ☐ Traumatic brain injury
- ☐ Autism spectrum disorder
- ☐ Specific learning disorder: _____
- ☐ Emotional disturbance: _____
- ☐ Other health impairment: _____

Does your teen currently have a 504 plan? Yes No

If yes, for what: _____

Please describe any formal or informal school interventions or supports your teen currently receives: _____

_____

_____

Do you have concerns about your teen's academic performance? (e.g., grades) Yes No

If yes, please describe: _____

_____

_____

Do you have concerns about your teen's social relationships? (e.g., friends, peers, romantic relationships) Yes No

If yes, please describe: _____

_____

_____

Below is a list of things teens may experience. Check any/all that apply to your teen:

- ☐ 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
- ☐ Other event(s) that significantly upset teen:
- ☐ 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

Signature:_____ **Date:**_____