CENTER FOR BEHAVIORAL MEDICINE

Patient Name: _____

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

Instructions: Clients 14 years and older are encouraged to complete the following questions themselves with the assistance of their parents if necessary in order to assist your therapist in better understanding your situation. Parents of children under 14 years of age are asked to complete this form for their child.

Name: _____ Age: _____ Date of Birth: _____

Racial Identity: (Check all that apply)

- ☐American Indian or Alaska Native
- ☐Asian or Asian American
- ☐Other: _____
- ☐Hispanic or Latino
- ☐White
- ☐Native Hawaiian or Pacific Islander
- ☐ Black or African American

PRESENTING PROBLEM

Check if you are experiencing any of the following problems:

- ☐Alcohol abuse
- ☐Drug abuse
- ☐Anxiety
- ☐Depression
- ☐Family / Friends
- ☐ Relationships
- ☐Sexual issues / Orientation
- ☐Eating habits
- ☐Stress management
- ☐Physical health

We would appreciate learning more about you and your perspective on your life. Please describe, in detail, why you checked the above items. Tell us about your challenges, strengths, your needs and any family or community support you have in your life:

_____

_____

_____

_____

_____

_____

_____

_____

_____

What goals would you like to accomplish in treatment:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

Patient Name: _____

ADOLESCENT SYMPTOM CHECKLIST

The following is a list of symptoms that have to do with various psychological problems that children or adolescents may experience. Please circle the number from zero (0) to four (4) that best describes how much this symptom or problem bothers you. Use the following scale:

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

In the past week, how much were you bothered by:	Not at all		Moderately		Extremely
1. Feeling depressed or discouraged	0	1	2	3	4
2. Feeling easily annoyed or irritated	0	1	2	3	4
3. Feeling little interest in things or avoiding enjoyable activities, family or friends	0	1	2	3	4
4. Feeling unemotional or without feeling	0	1	2	3	4
5. Having difficulty making or keeping friends	0	1	2	3	4
6. Frequently refusing to attend or missing school/work	0	1	2	3	4
7. Feeling worthless or hopeless about the future	0	1	2	3	4
8. Refusing to eat (no appetite) or eating excessively	0	1	2	3	4
9. Having difficulty sleeping or appears tired/sleepy during the day	0	1	2	3	4
10. Thoughts of suicide: thinking “I wish I were dead,” “life isn’t worth living anymore”	0	1	2	3	4
11. Suicide attempt: intent or action to hurt or kill self with pills, weapons, cuts, etc.	0	1	2	3	4
12. Racing thoughts, rapid speech or feeling overly high in mood	0	1	2	3	4
13. Being easily distracted or trouble concentrating, can’t stay focused on activities	0	1	2	3	4
14. Feeling so restless you can’t sit still	0	1	2	3	4
15. Failing to finish things that you have started	0	1	2	3	4
16. Acting without thinking (impulsively)	0	1	2	3	4
17. Difficulty paying attention	0	1	2	3	4
18. Feeling anxious: worrying excessively or worrying about many things	0	1	2	3	4
19. Feeling unreasonable fear of strangers	0	1	2	3	4
20. Expressing negative or critical things about yourself	0	1	2	3	4
21. Experiencing physical problems such as headaches, nausea, dizziness etc.	0	1	2	3	4
22. Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
23. Sudden re-experiencing of feelings, thoughts, images of a traumatic event	0	1	2	3	4
24. Urinating or having bowel movements in a place other than the toilet	0	1	2	3	4
25. Believing that others know what you are thinking	0	1	2	3	4
26. Recurrent thoughts, impulses, or images that are intrusive and troubling	0	1	2	3	4
27. Excessive repeating of an activity that you couldn’t resist even though it sometimes seems foolish (e.g., cleaning, washing hands, counting, etc.)	0	1	2	3	4
28. Feeling that you are watched or talked about by others	0	1	2	3	4
29. Seeing or hearing things outside yourself that others tell you are not really there	0	1	2	3	4
30. Repeatedly make odd movements or strange facial expressions	0	1	2	3	4
31. Mumbling, making unusual vocal noises or speaking in a disorganized way that does not make sense	0	1	2	3	4
32. Lying, cheating, or stealing	0	1	2	3	4

33. Expressing considerable and sustained interest in sexual activities	0	1	2	3	4
34. Expressing a lack of fear of getting hurt in dangerous activities	0	1	2	3	4
35. Expressing an interest in violence, death, accidents etc.	0	1	2	3	4
37. Hurting, pushing or physically threatening others	0	1	2	3	4
38. Having urges to break or smash things	0	1	2	3	4
39. Getting into frequent arguments with family members or teachers	0	1	2	3	4
40. Educational concerns such as poor academic performance or poor conduct in school	0	1	2	3	4
41. Other:	0	1	2	3	4

For the next several questions, please circle the number that represents how frequently you use any of the following substances.
Use the following scale:

0 = Never 1 = In past, not currently 2 = Monthly 3 = Weekly 4 = Almost daily

	Never	In Past	Monthly	Weekly	Daily
a.Caffeine: coffee, caffeinated beverages	0	1	2	3	4
b.Nicotine: cigarettes, cigars	0	1	2	3	4
c.Beer / Liquor	0	1	2	3	4
d.Marijuana, hash	0	1	2	3	4
e.Sedatives: tranquilizers, sleeping pills, barbiturates, valium, xanax, Quaaludes	0	1	2	3	4
f.Inhalents / Solvents: glue, toluene, gasoline	0	1	2	3	4
g.Stimulants: amphetamines, “speed”, Ritalin	0	1	2	3	4
h.LSD, psychedelics, mescaline, peyote, DMT, ecstasy	0	1	2	3	4
i.Cocaine / Crack / Crank, coca leaves	0	1	2	3	4
j.Opioids: herion, codeine, Demerol, morphine, percodan, methadone, darvon, oxycodone	0	1	2	3	4
k.PCP, “angel dust”, ketamine	0	1	2	3	4
l.Other:	0	1	2	3	4

PSYCHOLOGICAL HISTORY

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? Yes No
If yes, what and when:

_____

_____

_____

Have you ever been in counseling or psychotherapy before? Yes No
If yes, where and when: _____

_____

_____

Have you had any past hospitalizations for emotional problems? Yes No
If yes, when and where: _____

_____

_____

Have you ever intentionally hurt yourself or made a suicide attempt? Yes No
If yes, explain how and when: _____

_____

Patient Name: _____

MEDICAL HISTORY

Check if you are currently experiencing or have ever experienced:

- ☐Head injury
- ☐Heart (trouble, disease, surgery)
- ☐Heart murmur
- ☐Heart pacemaker
- ☐Rheumatic fever or heart disease
- ☐Abnormal blood pressure
- ☐Ulcers/abdominal pain
- ☐Diabetes
- ☐Epilepsy (Seizure Disorder)
- ☐Tuberculosis or lung disease
- ☐Emphysema
- ☐Cancer / tumors
- ☐Anemia
- ☐Thyroid problem
- ☐Kidney or bladder problems
- ☐Liver disease
- ☐Jaundice/rashes/sores
- ☐Hepatitis – type A B C
- ☐Arthritis / Rheumatism
- ☐Headaches
- ☐Hemophilia/blood disease
- ☐Sickle Cell disease
- ☐Stroke
- ☐Fainting spells
- ☐Asthma or hay fever
- ☐Sinus problems
- ☐Weight change/change in appetite
- ☐Glaucoma/Cataracts
- ☐Neurological disorders
- ☐Memory loss
- ☐Venereal disease
- ☐HIV positive / AIDS / ARC
- ☐Hearing impaired
- ☐Visual problems
- ☐Broken bones
- ☐Other _____

If you checked any of the above medical items, please explain:

_____

_____

_____

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

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

Are you currently experiencing any physical pain? Yes No
If yes, where is the pain: _____

Are you currently receiving care for your pain? Yes No
By whom: _____

Do you have any allergies or reactions to medication? Yes No
If yes, what medications: _____

Are you taking any prescribed medications? Yes No

Name of medication	Dosage and Frequency	Reason	Physician

Please indicate any herbal or homeopathic substances that you are currently taking: _____

Patient Name: _____

FAMILY HISTORY

Please list Parents, Siblings, Spouse/Partner, Children, and Significant Relatives/Others:

Name (First & Last)	Relationship	Age	School / Occupation	City of Residence

How many pregnancies have you experienced? _____

Where were you born?_____

Who currently lives in your household? _____

_____

Is there a history of depression, anxiety, alcoholism, or other mental health conditions in your family? Yes No
If yes, who? What was the problem? Did they receive treatment or medication? _____

_____

_____

_____

Have you ever experienced any emotional, physical, or sexual abuse? Yes No
If yes, please explain: _____

_____

_____

_____

Have you ever been accused of assaulting or inappropriately touching someone? Yes No
If yes, please explain who / when: _____

_____

Does the use of alcohol or drugs by someone close to you contribute to your problems? Yes No
If yes, please explain: _____

_____

_____

_____

Did you grow up in a home in which a parent abused alcohol or drugs? Yes No

Patient Name: _____

EDUCATIONAL & VOCATIONAL HISTORY

What grade are you currently in? _____ Name of school: _____

Who is the contact person (principle or counselor) at your school? _____

How are you doing academically in school? _____

How is your conduct in school? _____

Are you in any special classes in school (speech, LD, ED, accelerated)? YES or NO
If YES, please explain:
_____

What extracurricular activities are you involved in?_____

Have your relationships with your friends changed recently? _____

What hobbies or interests do you have? _____

Do you work or have a job? If yes, list job/title: _____

How many hours per week? _____

Have you ever been fired? YES or NO If yes, explain: _____

Do you have any language or reading difficulties? YES or NO If yes, explain: _____

LEGAL HISTORY

Do you have a legal history consisting of past or current:

Arrests	Yes	No	Explain: _____
Misdemeanor Charges	Yes	No	Explain: _____
Criminal Charges	Yes	No	Explain: _____
Legal Guardianship/Protective			Placement: _____
Probation	Yes	No	Explain/Name of PO: _____

CULTURAL / RELIGIOUS / SPIRITUAL HISTORY

What is your ethnic or cultural heritage? _____

In what religion did you grow up? _____ Your current religion? _____

How does your ethnicity or religious beliefs influence your life? _____

Signature of person completing this form:_____ Date: _____

Parent/Guardian Signature:_____ Date: _____