

Patient Name: _____

**Biopsychosocial History & Assessment
Parent Report (Part C)**

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

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

Date of Birth: _____ Age: _____ Gender: _____ Language: _____

Lives with: _____ Relationship: _____

Primary Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent name: _____ Age: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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

Parent has (circle all that apply): Primary Custody Joint Custody Primary Placement

 Shared placement Other

Other members of household: _____

Parent name: _____ Age: _____

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

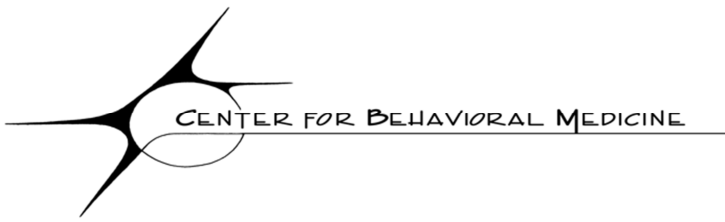
Home Phone: _____ Cell Phone: _____ Work Phone: _____

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

Parent has (circle all that apply): Primary Custody Joint Custody Primary Placement

 Shared Placement Other

Other members of household: _____



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Siblings Names	Sex	Age	Type (bio, half, step, etc)	Living situation

Name of Parent/Guardian completing form: _____ Date: _____

What problem or problems is your child having that concerns you?

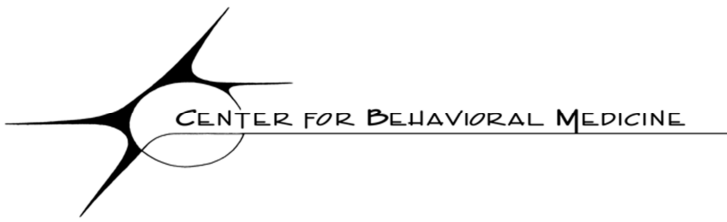
When did the problem start?

Has the child ever received mental health treatment? If so, where, when, and by whom? _____

Has your child ever taken medication for an emotional or behavioral problem? If yes, what medication, when and prescribed by whom? _____

Describe your child's strengths: _____

In the past month, what has been your child's biggest success or accomplishment? _____



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Who does your child look to for support? _____

What are your family's strengths? _____

Who do you as a parent rely on for support and assistance? _____

Is your child receiving any other help or therapy? (List) _____

Medical and Developmental History

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

Pregnancy Mother was healthy Mother had health problems: _____
 Mother smoked Mother used alcohol Mother used drugs
 Violence towards mother during pregnancy

Delivery Full-term Premature at _____ months Adopted at _____ of age
 Medical complications : _____
 Congenital complications: _____
 Extended hospital stay for infant Extended hospital stay for mother

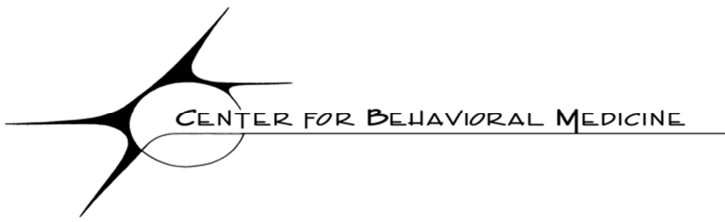
Has your child had a history of medical problems? _____

Have there been significant hospitalizations, operations, procedures or injuries? (Describe) _____

Are there any current medical problems or concerns? (Describe) _____

Child's Primary Care Physician: _____ Phone: _____

Child's Prescribing Psychiatrist: _____ Phone: _____



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Has your child seen the Primary Care Physician within the past year? Yes No

Below is a list of developmental concerns or problems. Please check all that apply to your child.

✓	Description	At what age?	Current Status
	Slow to crawl		
	Slow to walk		
	Slow to talk		
	Not like to be touched or held		
	Difficulty with toilet training, bedwetting, soiling		
	Problems with sleep		
	Problems with eating		
	Easily upset/hard to calm down		
	Not like being around people		
	Too active for the child's age		
	Low energy		
	Physical disability		
	Learning problems		
	Other:		

Check and complete if your child is enrolled in:

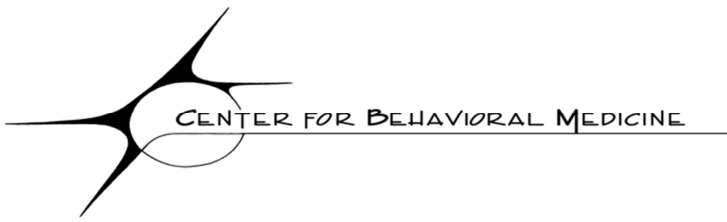
School Name: _____ Address: _____
 Teacher: _____ Grade: _____
 Phone Number: _____
 Does your child have an IEP? No Yes, for _____

Childcare Name: _____ Address: _____
 Phone: _____ Contact Person: _____

Other program Name: _____ Address: _____
 Phone: _____ Contact Person: _____

Below is a list of experiences that children/adolescents may have to deal with. Check all that apply to your child.

✓	Description	✓	Description
	Teasing or bullying by another		Drug/alcohol problem of a parent
	Conflict in family		Foster care
	Separation from parents		Physical abuse
	Frequent moves in location		Sexual abuse
	Divorce		Emotional or verbal abuse
	Medical procedure or emergency		Witnessing violence at home



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Death or loss of someone close	Witnessing violence in the community
Medical problem of a parent	Natural disasters
Emotional problem of a parent	Car crash or other serious accident
Family member victim of a crime	Child victim of a crime
Other event that extremely upset child (Describe):	

What would you like to see change for your child as a result of treatment? For yourself as a parent? _____

Signature: _____

Date: _____