CENTER FOR BEHAVIORAL MEDICINE

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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Biopsychosocial History & Assessment
Parent Report (Part C)

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

	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:_____