Family Service Society, Inc.

"√" if SCANNED TO EMR	INITIALS

Return to Front Desk if not √ Checked and Initialed

Client's Biopsychosocial Assessment – Adolescent/Youth ONLY

Client Name: _____ **Date of Birth:** ____/____/____

Guardian Name *(if applicable)*: _____

Race / Ethnicity:

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Two or More Races ☐ Asian
☐ Native Hawaiian and Other Pacific Islander ☐ Prefer not to disclose ☐ Other_____

Marital History:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower ☐ Re-Married ☐ Prefer not to disclose
☐ Other_____

Gender Identity / Expression:

☐ Male ☐ Female ☐ Male-to-Female/Transgender ☐ Female-to-Male/Transgender
☐ Genderqueer, neither exclusively male nor female ☐ Prefer not to disclose
☐ Other_____

Sexual Orientation:

☐ Straight or Heterosexual ☐ Homosexual, Gay, or Lesbian ☐ Bisexual ☐ Prefer not to disclose
☐ Other_____

Current Living Situation (*check 1*)**:**

☐ Own Home ☐ Foster Care ☐ Relative Placement ☐ Legal Guardian ☐ Pre-Adoptive Home
☐ Emergency Shelter ☐ Group Home ☐ Jail/Juvenile Detention
☐ Other_____

History of Living Situations (check any that have ever applied):

☐ Own Home/parent's home as an adult ☐ Foster Care ☐ Relative Placement as a child
☐ Legal Guardian ☐ Pre-Adoptive Home ☐ Emergency Shelter ☐ Group Home ☐ Jail/Juvenile Detention
☐ Other_____

Supportive Individuals:

Name:	Relationship:	Age:	Quality of Relationship:
			☐ Generally Positive ☐ Great ☐ Excellent
			☐ Generally Positive ☐ Great ☐ Excellent
			☐ Generally Positive ☐ Great ☐ Excellent
			☐ Generally Positive ☐ Great ☐ Excellent

Education History: (*Highest Completed Education*)

☐ High School ☐ GED ☐ Some College ☐ College ☐ Masters/PHD
☐ IEP - Individualized Education Program ☐ Dropped Out

Legal Status / Criminal History:

☐ None Reported ☐ Arrested ☐ Current Probation/Parole ☐ Past Probation/Parole

Charges: _____ ☐ Sentencing ☐ Dismissed

Time Served: _____

☐ Current Court Involvement (details) _____
☐ Previous Court Involvement (details) _____
☐ Previous Child Welfare Services Involvement (details) _____

Employment History:

☐ Part-Time ☐ Full-Time ☐ Unemployed ☐ Retired ☐ Veteran ☐ Active Duty ☐ N/A

Current Employment: _____

Previous Employment: _____

Financial Status:

Do you receive public assistance (i.e. WIC, SNAP, TANF?) ☐ Yes ☐ No

Do you worry about money or making your bills? ☐ Yes ☐ No

Do you have a budget? ☐ Yes ☐ No

Access to Transportation:
What kind of transportation do you use to get to and from work, school, and/or your appointments?

_____

Are there times when a lack of transportation prevents you from attending work, school, or your important appointments? ☐ Yes ☐ No

Access to Resources:
What are some of the agencies or examples of community involvement or agencies that you've been involved with over the past few months/years?

_____

Family Safety and Interactions:

Do you feel emotional support within your family?

☐ Yes ☐ No

How do you feel your family handles conflict?

Does anyone in the household regularly push, slap, grab or throw something at you?

☐ Yes ☐ No

Has anyone in the household struck you hard enough that marks were left or were you injured?

☐ Yes ☐ No

What are your daily family routines? (e.g. family dinner, bedtimes, morning routines, etc.)

How do you celebrate birthdays, holidays, or other cultural traditions?

Mental Health Diagnosis & Treatment History:

Diagnosis _____ Treatment _____ Length of Treatment _____

☐ Is this current? = How do you feel you are doing & is Diagnosis being managed: ○ Good ○ Fair ○ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

☐ Is this current? = How do you feel you are doing & is Diagnosis being managed: ○ Good ○ Fair ○ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

☐ Is this current? = How do you feel you are doing & is Diagnosis being managed: ○ Good ○ Fair ○ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

☐ Is this current? = How do you feel you are doing & is Diagnosis being managed: ○ Good ○ Fair ○ Poor

Wellness Assessment(s) – Current symptoms within the last week:

Wellness Assessment – Youth Only

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other_____

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	Never	Sometimes	Often
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	Not at All	A Little	Somewhat	A Lot
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+

24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days

25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days

Medical History:

Medication(s):

Drug Name:	Reason:	Current:	Helpful/Effective
		Yes No	Yes No
		Yes No	Yes No
		Yes No	Yes No
		Yes No	Yes No
		Yes No	Yes No
		Yes No	Yes No

History of Hospitalization(s) (*physical or mental health related*):

Hospital:	Reason:	Diagnosis:	Helpful/Effective
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Additional Medication(s):

Allergies:

Current Health/Medical Conditions:

Previous Health Conditions:

Disabilities: ☐ N/A

Conditions That May Impact Counseling (*issues of concern*):

☐ Dental ☐ Vision ☐ Hearing ☐ Other _____

Substance Abuse History: ☐ N/A

Substance:	Typical Amount Used:	Duration of Use/Abuse:	
			☐ Current
			☐ Current
			☐ Current
			☐ Current
			☐ Current

Drug of Choice:				☐ Current

Treatment Preferences (*include individual needs*):

☐ Individual ☐ Family ☐ Group ☐ Other _____

Personal / Family Strengths:

Abilities/Interests:

_____ _____ / / **Client (Guardian) Signature** **Date**