

HEALTHY MINDS FOR HEALTHY LIVES

Merrill Wood DNP, APRN, CPNP-PC, PMHS, BICBT-CC
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BIOPSYCHOSOCIAL INTAKE ASSESSMENT & CLIENT INFORMATION - MINORS

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Birthplace: _____

Gender: _____ Race: _____ Ethnicity: _____

Address: _____

Name of parent(s)/guardian(s) who have legal custody of child:

** Address if parent/guardian lives in another residence:*

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail? YES NO

Email Address: _____

Is it ok to email you? YES NO

How were you introduced to us? _____

Primary Care Provider/Pediatrician _____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one?

1. _____
2. _____
3. _____

What do you think your child would say their biggest concern(s) is/are?

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What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

Have you or your child(ren) had therapy or mental health services in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results.

What change would you like to see in your child/teen life and your family's life?

List 3 strengths about your child:

1. _____
2. _____
3. _____

Medical Background

Has your child ever received mental health services before?

YES NO

If yes, how long ago, with whom, for what, and results:

Many parents have opinions on psychiatric medications, what are yours?

Does your child have any allergies (food, environmental, medicinal, animal, etc.)

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

Is your child presently under a physician's care? If so, for what?

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:

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Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

Tell us about your child's development milestones (delayed, on time, early)

Important Questions We Must Ask

Has your child ever had thoughts of killing themselves? If yes, please explain:	YES	NO
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Has your child ever planned on killing themselves? If yes, please explain:	YES	NO
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Has your child ever attempted to kill themselves? If yes, please explain:	YES	NO
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Has anyone in your family or close to you died by suicide? If yes, please explain:	YES	NO
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Has your child ever felt like they wanted to seriously hurt or kill someone else? If yes, please explain:	YES	NO
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Do you have weapons in your home or access to weapons? If yes, who has access to them and what are the safety protocols around them?	YES	NO
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Is there any past or present abuse or violence? If so, please explain:	YES	NO
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Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

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Has your child ever witnessed or experienced a trauma? Have reoccurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? If so, please explain:

Are you concerned your child may see or hear things that don't appear to be real? If so, please explain:

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put them at risk? If so, please explain?

Do you have any concerns about your child's sexuality, gender or sexual development?

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or received specialized academic services? If so, for what?

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc)?

What would your child say they like and dislike about school:

Likes: _____

Dislikes: _____

What responsibilities does your child have at home?

Does your child have their own cell phone?

YES

NO

What are the rules around your child's cell phone use? Who enforces those rules?

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Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

If 1 or both parents are absent, if so for how long and reason for absences:

If parents are not together, please describe the parents' relationship with one another:

Who lives in the house with the child?

If parents are not together, who lives in the other house with the child?

Does your family have any pets? If yes, names, types and relationship to each pet:

Name, relationship and description of relationship below:

Parent 1: _____

Parent 2: _____

Step-parents or parent's significant other:

Siblings: Age, Name and Sex:

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

Other important relationships:

Who else do you consider to be part of or supportive to your family (people or affiliations):

Is there anything else that you think is important for me to know about your child?
