Patient Name: ____ Date: ______________

CHILD/ADOLESCENT BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems: ____

____

____

Duration (months): ________________________

Additional Information: ____

____

CURRENT SYMPTOM CHECKLIST (Rate intensity currently present)

None=This symptom not present at this time • **Mild**=Impacts quality of life, but not significant impairment of day-to-day functioning • **Moderate**= Significant impact on quality of life and/or day-to-day functioning • **Severe**=Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe	Unsure
Depressed mood	☐	☐	☐	☐	☐
Appetite disturbance	☐	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	☐
Elimination disturbance	☐	☐	☐	☐	☐
Fatigue/low energy	☐	☐	☐	☐	☐
Psychomotor retardation	☐	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	☐
Poor grooming	☐	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	☐
Agitations	☐	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐
Generalized anxiety	☐	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	☐
Obsessions/compulsions	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Binging/purging	☐	☐	☐	☐	☐
Laxative/diuretic abuse	☐	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	☐
Paranoid ideation	☐	☐	☐	☐	☐
Circumstantial symptoms	☐	☐	☐	☐	☐
Loose associations	☐	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	☐
Aggressive behaviors	☐	☐	☐	☐	☐
Conduct problems	☐	☐	☐	☐	☐
Oppositional behavior	☐	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐	☐
Grief	☐	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Guilt	☐	☐	☐	☐	☐
Elevated mood	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Dissociative states	☐	☐	☐	☐	☐
Somatic complaints	☐	☐	☐	☐	☐
Self-mutilation	☐	☐	☐	☐	☐
Significant weight gain/loss	☐	☐	☐	☐	☐
Concomitant medical cond.	☐	☐	☐	☐	☐
Emotional trauma victim	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Physical trauma victim	☐	☐	☐	☐	☐
Sexual trauma victim	☐	☐	☐	☐	☐
Emotional trauma perpetrator	☐	☐	☐	☐	☐
Physical trauma perpetrator	☐	☐	☐	☐	☐
Sexual trauma perpetrator	☐	☐	☐	☐	☐
Substance use/abuse	☐	☐	☐	☐	☐
Homicidal ideation	☐	☐	☐	☐	☐
Suicidal ideation	☐	☐	☐	☐	☐

Suicide Attempts: ________ number of times

Date of last attempt: ______________________________

Other (specify): ______________________________

____

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy? _______ Yes _______ No
If yes on _____ occasions. Longest treatment by ________________________ for _____ sessions from _____/_____ to _____/_____
Prior provider name: ___________________________________
City: ____________________________ State: ____________________
Phone: ____
Diagnosis: ____
Intervention/Modality: ____
____
Beneficial? ____

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?________ Yes _______ No
If yes on _____ occasions. Longest treatment by ________________________ for _____ sessions from _____/_____ to _____/_____
Inpatient facility name: _______________________________________
City: ____________________________ State: ____________________
Phone: ____
Diagnosis: ____
Intervention/Modality: ____
____
Beneficial? ____
Has any family member had outpatient psychotherapy? _______ Yes _______ No
Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder
If yes, who/why (list all): ____
____

EDUCATION LEVEL:

Current grade ____________________ School attending ____

FAMILY HISTORY

FAMILY OF ORIGIN
Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
Mother	☐	☐	☐
Father	☐	☐	☐
Stepmother	☐	☐	☐
Stepfather	☐	☐	☐
Brother(s)	☐	☐	☐
Sister(s)	☐	☐	☐
Other (specify)	☐	☐	☐

Father
Full name:__________________________________
Occupation:________________________________
Education level:_____________________________
General health:______________________________

Mother
Full name:____
Occupation:____
Education level:_____________________________________
General health:______________________________________

Describe childhood family experience:

- ☐ Outstanding home environment
- ☐ Normal home environment
- ☐ Chaotic home environment
- ☐ Witnessed physical/verbal/sexual abuse toward others
- ☐ Experienced physical/verbal/sexual abuse from others

Age of emancipation from home:______ Circumstances:____
____
Special circumstances in childhood:____

List all persons currently living in patient's household:

Name	Age	Gender	Relationship to patient

List any siblings living outside the household:

Name	Age	Gender	Relationship to patient

Substance use history:

Family alcohol/drug abuse history:

- ☐ Mother ☐ Stepmother/live-in ☐ Grandparent(s) ☐ Spouse/significant other
- ☐ Father ☐ Stepfather ☐ Uncle(s)/Aunt(s) ☐ Siblings
- ☐ Other (Specify)____

Patient alcohol and/or drug treatment history:

- ☐ Outpatient (age[s]________) ☐ Inpatient (age[s]____________)
- ☐ 12-step program (age[s]___________) ☐ Stopped on own (age[s]__________)
- ☐ Other (age[s]________________) describe:____

Substances used by patient:

(complete all that apply)	First use age	Last use age	Current Use (yes/no)	Current frequency	Current amount
Alcohol					
Amphetamines/"speed"					
Barbiturates/"downers"					
Caffeine					
Cocaine					
Crack cocaine					
Hallucinogens (e.g. LSD)					
Inhalants (e.g. glue, gasoline)					
Marijuana or hashish					
Nicotine/cigarettes					
PCP					
Prescription					
Other					

Consequences of substance use (check all that apply):

- ☐ Hangovers ☐ Seizures ☐ Assaults ☐ Loss of control of amount used ☐ Withdrawal symptoms ☐ Medical complications
- ☐ Blackouts ☐ Overdose ☐ Arrests ☐ Sleep Disturbance ☐ Suicidal Impulse ☐ Relationship conflicts
- ☐ Binges ☐ Job loss ☐ Tolerance changes ☐ Other ______________________________

DEVELOPMENTAL HISTORY (check all that apply for the child/adolescent patient)

Problems during mother's pregnancy:

☐ None ☐ Alcohol use ☐ Drug use ☐ Bleeding ☐ Kidney infection ☐ High blood pressure

☐ German Measles ☐ Emotional stress ☐ Cigarette use ☐ Other ___________________

Birth: ☐ Normal delivery ☐ Difficult delivery ☐ Cesarean delivery ☐ Complications

Birth weight: _______lbs _________ oz.

Infancy: ☐ Feeding problems ☐ Sleep problems ☐ Toilet training problems

Childhood health:

☐ Chicken Pox age: _________ ☐ German Measles age: ______ ☐ Red Measles age: _________ ☐ Mumps age: _____________

☐ Rheumatic fever age: ______ ☐ Whooping cough age: ______ ☐ Scarlet Fever age: _________ ☐ Diptheria age: ____________

☐ Lead poisoning age: _______ ☐ Poliomyelitis age: _________ ☐ Pneumonia age: __________ ☐ Tuberculosis age: _________

☐ Autism ☐ Mental retardation ☐ Ear infections ☐ Asthma

Significant injuries: ______________________________________

Chronic, serious health problems: ___________________________

Delayed developmental milestones (check **only** those milestones that **did not** occur at expected age):

☐ Sitting ☐ Rolling over ☐ Standing ☐ Walking ☐ Feeding self

☐ Speaking words ☐ Speaking sentences ☐ Controlling Bladder ☐ Sleeping alone ☐ Dressing self

☐ Engaging peers ☐ Tolerating separation ☐ Playing cooperatively ☐ Riding tricycle ☐ Riding bicycle

Social interaction (check all that apply):

☐ Normal social interaction ☐ Isolates self ☐ Very shy ☐ Alienates self

☐ Dominates others ☐ Inappropriate sex play ☐ Associates with acting-out peers ☐ Other

Emotional/behavioral problems (check all that apply):

☐ Drug abuse ☐ Alcohol abuse ☐ Chronic lying ☐ Disobedient ☐ Repeats words of others

☐ Stealing ☐ Violent temper ☐ Fire-setting ☐ Indecisive ☐ Self-injurious threats

☐ Hyperactive ☐ Animal cruelty ☐ Assaults others ☐ Immature ☐ Self-injurious acts

☐ Distrustful ☐ Bizarre behavior ☐ Extreme worrier ☐ Impulsive ☐ Frequent daydreams

☐ Often sad ☐ Breaks things ☐ Easily distracted ☐ Not trustworthy ☐ Poor concentration

☐ Hostile/angry mood ☐ Lack of attachment ☐ Frequently tearful ☐ Other

Describe any other development problems or issues: ____

Intellectual/academic functioning (check all that apply):

☐ Normal intelligence ☐ High intelligence ☐ Learning problems ☐ Authority conflicts

☐ Attention problems ☐ Underachieving ☐ Mild retardation ☐ Moderate retardation ☐ Severe retardation

Legal history:

☐ No legal problem ☐ Now on parole/probation ☐ Arrest(s) not substance-related

☐ Arrest(s) substance related ☐ Court ordered this treatment ☐ Describe last legal difficulty:

☐ Jail/prison ____ times ☐ Total time served:_______ ________________________________

HEALTH SCREENING

Patient's Name: ____ Date: __________________

Date of Birth: ____ Sex: ______F ______ M

Allergies: ____

1. Do you have or have you ever had any of the following?
   (please check yes or no)

	No	Yes	Please describe
Allergies			
Blood Disorder			
Bone or Joint Problems			
Cancer			
Diabetes			
Endocrine Disorders (e.g. thyroid)			
Epilepsy (seizures, convulsions)			
Gastrointestinal Disorders (stomach)			
Head injury			
Heart Disease			
HIV/AIDS Related Conditions			
Hypertension (high blood pressure)			
Hypoglycemia (low blood sugar)			
Liver Disease			
Lung Disease			
Physical Limitations			
Sexually Transmitted Disease (e.g. gonorrhea, syphilis)			
Other			

2. HOSPITALIZATIONS (list any operations, medical procedures, mental, drug, or alcohol abuse treatment)

Date	Procedure/treatment

3. MEDICATION currently taking (include prescription drugs; amount and frequency)

Name of Medication	Amount	Frequency	Date Started

4. MEDICAL PROCEDURES Physical exams; special test e.g. EKG, Blood Tests, X-rays, within past year

Exam/Test Performed	Date	Physician/Clinic

5. PRIMARY CARE DOCTOR

Name	Address	Phone	Date of Last Physical Exam

6. PREVIOUS MENTAL HEALTH TREATMENT

Date	Name of Provider	Address	Phone

Parent/Guardian/Patient's Signature: ______________________________ Date: _______________

Patient Name: Date of Birth:

Married Parents/ Joint Custody

PARENT 1

Authorization to Provide Services to Minors
(Persons Under Age 18)

I,________PARENT NAME________, authorize mental health treatment services from ________PROVIDER NAME________ for my son/ daughter, ____CHILD NAME____, who is ___AGE___ years of age. I agree to be present, and when requested, to participate in the treatment process.

I understand that all information given to ______PROVIDER NAME______, and obtained from outside sources, will be retained in the patient's medical records and will remain confidential. No information will be shared with anyone outside of the practice of the provider listed above without consent of the parent or guardian.

Parent/ Legal Guardian Printed Name

NOTARY SIGN/STAMP

Parent/ Legal Guardian Signature

Notary Stamp

Date

Date

1311 Union Street
Schenectady, NY 12308
518-374-6263

5 Hemphill Place
Malta, NY 12020
518-289-5072

All Providers are in Private Practice

Married Parents/ Joint Custody

PARENT 2

Authorization to Provide Services to Minors
(Persons Under Age 18)

I,____PARENT NAME____, authorize mental health treatment services from ____PROVIDER NAME____ for my son/ daughter, ____CHILD NAME____, who is ____AGE____ years of age. I agree to be present, and when requested, to participate in the treatment process.

I understand that all information given to ____PROVIDER NAME____, and obtained from outside sources, will be retained in the patient's medical records and will remain confidential. No information will be shared with anyone outside of the practice of the provider listed above without consent of the parent or guardian.

____
Parent/ Legal Guardian Printed Name

____
Parent/ Legal Guardian Signature

NOTARY SIGN/STAMP
____
Notary Stamp

____
Date

____
Date

1311 Union Street
Schenectady, NY 12308
518-374-6263

5 Hemphill Place
Malta, NY 12020
518-289-5072

All Providers are in Private Practice

SINGLE PARENT/ SOLE CUSTODY

Authorization to Provide Services to Minors
(Persons Under Age 18)

I,______PARENT NAME______, authorize mental health treatment services for ______CHILD NAME______, my son/ daughter, who is ___AGE___ years of age. I agree to be present, and when requested, to participate in the treatment process. By signing below I attest that I possess sole decision making rights for all medical care for my child. I hereby hold harmless Union Street Counseling Services LLC., and provider______PROVIDER NAME______ from any claims made by another parent/legal guardian regarding the above mentioned decision making rights.

I understand that all information given to ______PROVIDER NAME______, and obtained from outside sources, will be retained in the patient's medical records and will remain confidential. No information will be shared with anyone outside of the practice of the provider listed above without consent of the parent or guardian.

____
Parent/ Legal Guardian Printed Name

____
Parent/ Legal Guardian Signature

NOTARY SIGN/STAMP
____
Notary Stamp

____
Date

____
Date

PRMARY CARE PROVIDER (PCP) COORDINATION OF CARE

This release is for the purpose of coordination of care between your provider at Union Counseling and your Primary Care Provider/ General Practitioner. **COMPLETE TOP SECTION ONLY.**

Patient Name:____

Patient Date of Birth:____

Patient Address:____

____

Primary Care Provider (PCP) Name:____

Address:____

____

Phone:______________________ Fax:______________________

Optional Refusal (Initial):

_____I **AM NOT** currently receiving services from a PCP or other medical practitioner

_____I **DO NOT** want information shared with my PCP

NOTICE: *By signing, I hereby authorize the behavioral health clinician/facility listed below to release information to the practitioner/provider listed above. The reason for disclosure is to facilitate continuity and coordination of treatment.* ***This consent will last one year from the date signed****. I understand that I may revoke my consent in writing at any time. I understand that my treatment is not conditional in any way on my consenting to this disclosure.*

Signature of Patient/Patient's Representative:______________________**Date**:____________

Print Name of Patient/Patient's Representative:______________________

Relationship of Representative (parent, guardian, etc.)______________________

(Please provide necessary documentation proving authority if requested)

THIS DOCUMENT IS FOR COORDINATION OF CARE ONLY FOR OUR MUTUAL PATIENT LISTED ABOVE

Should you have any further questions, please contact the office selected below.

Diagnosis: ____

____

____

Medications:____

____

____

I recommend the following course of treatment for this patient:

THERAPY: _____Individual ____Family _____Group _____Couple

MEDICAL: _____Medication Management ______Substance Abuse Treatment

Provider Name:______________________Credential:______________________

Provider Signature:______________________Date:______________________

☐ 1311 Union Street Schenectady, NY 12308 Phone:(518)374-6263 Fax: (518)374-1778

☐ 5 Hemphill Place Malta, NY, 12020 Phone:(518)289-5072 Fax: (518)289-5225

DATE SENT_______ STAFF INITIAL_______

ADULT YEARLY APPT