

The Network for Behavior Change, pc

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There are no obstacles, only hurdles of varying heights. None is so great that it can not be overcome, gotten around or gone under. Even mountains disintegrate with time.

INFORMATION QUESTIONNAIRE FOR BIO-PSYCHO-SOCIAL ASSESSMENT

NAME: _____ Phone: _____ Date: _____

MA #: _____ issue # _____ SS #: _____ - _____ - _____ DOB: _____

Referred by: _____ Date: _____ Phone: _____ Examiner: _____

Qualitative Observations (*describe the child's physical appearance & behavior during the interview. Note handedness (left, right or ambidextrous), balance/gait, eye contact, responsiveness (responded to humor, self-motivated, responded to prompts, etc.), verbal mediation use ("talking to self" to complete complex problems), approach to problem-solving (concrete, flexible, rigid), was this a valid sample of the child's strengths, weaknesses and needs?*)

Current Strengths (*list all exceptional physical, mental or emotional skills or abilities, including favorite sport(s), favorite school subject(s), anything he/she does often is probably a strength*)

Information Questionnaire for Bio-Psycho-Social Assessment By:

Current Needs and Concerns (*behavioral difficulties and/or mental health symptoms noting if these are different from those identified in the current Treatment Plan, if one exists*)

Summary of family resources, strengths and barriers to treatment (*attachment patterns, influence of parental experiences on parenting skills*)

Community resources, safety issues, peer group, cultural and related issues (*including SSI, SSDI, Family Driven Waiver services, other assistance received by the family from friends, relatives, etc. Does the child participate in YMCA, church youth group, community sports or other organized activities? Is the neighborhood considered safe? Are there any cautions about travel in the neighborhood?*)

Psychological-Psychiatric History (*Chronologically organized history of current behavioral symptoms, with recent exacerbations, precipitating and aggravating influences, including details about previous outpatient services including OP counseling, BHRS, Family-Based, etc. and treatment outcomes*)

Emotional Functioning History (*history of emotional stability and response to stressors*)

Educational History & School Behavior Concerns (*achievement including typical grades, classroom behavior, accommodations implemented by school, & apparent or existing Special Ed status*)

Spiritual History (*involvement in religious practices and any available church-related supports*)

Aggression & Suicidality History (*suicidal behavior, ideation, and history of aggression, if any*)

Information Questionnaire for Bio-Psycho-Social Assessment By:

Maturational History (*developmental milestones including walking talking, gross-motor and fine-motor development, toilet training, cognitive development, peer relationships, interests, hobbies and talents, and general physical fitness*)

Nutritional History (*dietary concerns, eating habits*)

Vocational History (*involvement in paid work activities, if any, or assistance with household chores*)

Legal History (*legal circumstances relevant to treatment, such as custody*)

Sexual History (*history of sexual abuse victimization, perpetration, or sexual experience base*)

Substance Abuse History (*including eating or mouthing of inedible objects*)

Medical Intervention History (*summary of the child's medical intervention history, including head trauma, seizures, Lyme Disease, CNS infection if any, medication usage, hospitalizations for medical reasons, surgeries, and other significant medical treatments and events*)

Current medical status (*ongoing serious illnesses, other current medical concerns*)

Family Medical History (*incidence of cardiac or respiratory illness in family members, mental illness in immediate family and grandparents, history of treatment response of family members*)

Non-BHR Services used in past, reason and effectiveness (*OT, PT, Speech, substance abuse services, etc*)

Summary of past BHR Services Progress (*BSC, MT, TSS only, with history of diagnoses rendered and response to treatment; the completed Behavior Record Graph showing data for the past 90 days is attached to the psychological evaluation report and is summarized here!*)

| Target behavior | Score |
|------------------------|--------------|
| | |
| | |
| | |

Current services (*identify the BHR Services that the child is currently receiving*)

Information Questionnaire for Bio-Psycho-Social Assessment By:

Noteworthy Effective Interventions (*identify the interventions that work well*)

Noteworthy Ineffective Interventions (*identify the interventions that have failed*)

Known barriers to Treatment (*any circumstances that could impede progress*)

Planned modifications of goals and Services (*what changes are you planning?*)

Mental Status Evaluation

Judgment: *Does the child know right from wrong? Is he/she self-protective & avoid danger?*

Thought: *Does the child hallucinate? Are there delusions? Are memory problems apparent?*

Mood: *Does the child's mood rise and fall in extremes? Is he/she prone to depression?*

Affect: *What is the child's typical emotional state (happy, depressed, suspicious, etc)?*

Impulse Control: *Can the child control impulses and tolerate delay in gratification?*

Psychosocial skills: *Can the child interact cooperatively with peers, or adults, or neither, or both?*

Psychomotor skills: *Unusual slowness in walking, talking, drawing, writing or other motor behavior?*

Physiological functions: *Is there any physical problem that influences behavior (such as seizures)?*

Perceptual: *Is there anything wrong with the child's senses (hearing, vision, smell, touch, taste)?*

Cognitive: *Is there any evidence of mental retardation (IQ < 72, poor social skills, age < 18)?*

Information Questionnaire for Bio-Psycho-Social Assessment By:

Preferred mode of communication: *(play, drawing, direct discourse)?***Consensus and agreements with child and caregivers** *(note concurrence with recommendations and Treatment Plan on the part of parent, child, pediatricians and other professionals, and school officials)***Preliminary Diagnoses****Axis I** _____**Axis II** _____**Axis III** _____**Axis IV** _____**Axis V** **Past:** _____ **Present:** _____**Proposed Treatment Plan Goals** *(especially the goals that the parent or teacher believes are necessary):*

| | |
|--------|--|
| Goal 1 | |
| Goal 2 | |
| Goal 3 | |

Non-BHR Services suggested *(including referral for psychotropic medication if not currently prescribed):*

Information Questionnaire for Bio-Psycho-Social Assessment By:

Initial Discharge Planning (*probable after-care placement and program*):**Requested Services****School-Related** (*identify times of day and days of the week that services are to be requested*):

| | M | T | W | R | F | SA | SU | |
|------------------|----------|----------|----------|----------|----------|-----------|-----------|--------------|
| FROM - TO | | | | | | | | TOTAL |
| HOURS | | | | | | | | |

Residential (*identify times of day and days of the week that services are to be requested*):

| | M | T | W | R | F | SA | SU | |
|------------------|----------|----------|----------|----------|----------|-----------|-----------|--------------|
| FROM - TO | | | | | | | | TOTAL |
| HOURS | | | | | | | | |

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Medical Resume Provided by: _____

Child's Name: _____ SS#: _____ - _____ - _____

Last Physical: _____ PCP & Phone: _____

In the chart below, please list ALL medications that have been used by this child
(continue on reverse if necessary)

| Medication Name | Daily Dose | Prescribing Physician | Reason Prescribed & Start Date (Stop Date, if applicable) |
|-----------------|------------|-----------------------|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |

Psychiatric history, hospitalizations, and major medical events *(use reverse if necessary)*:

Identify any allergies, medication or chemical **sensitivities** that have been observed in the child.
