Apex Therapeutic Services, PLLC
Healing Mind, Body & Spirit
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ADOLESCENT Comprehensive BioPsychoSocial History Interview& Diagnostic Assessment/Evaluation

Updated 2/25/16

The following Client information will be used to facilitate treatment planning and process. It may also be used to support/formulate the assignment of a DSM-V diagnosis. Please complete the information and place in Client's file. The information should be gathered before a formal assessment is completed but can also be used to develop a treatment plan and throughout the treatment process.

Client Name: _____
DOB: _____
Counselor Conducting Interview/Title: _____
Date of Interview: _____

Part 1: PARENT/GUARDIAN INTERVIEW RESPONSES RE: MINOR CLIENT

Name/Relationship of Person providing the information about Minor: _____
_____

Demographics
Age: _____ Race: _____
Legal Guardian: Self Parent Other: _____
Military Family: Y N Branch: _____
Current Living Situation:
Homeless Private Residence Facility Shelter Temporary Other:_____
Please list those currently living in Client's household: (Name, age, relationship)

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

REASON for this assessment. Presenting Issues/ Symptoms/Complaints:
Why are you seeking counseling for this MINOR?
***

Family of Origin History
Was Client adopted: Y N Details: _____
Where was Client born? _____
How many times has Client moved? _____
Who does Client live with? Mother Father Other: _____
Mother's name: _____ Age: ____ / Deceased: _____
Occupation: _____ Health _____
Where does she live now? _____
Current perceived relationship w/Mom: None Good Bad Rocky Other: _____

Father's name: _____ Age: _____ / Deceased: _____
Occupation: _____ Health _____
Where does he live now? _____
Current perceived relationship w/Dad: None Good Bad Rocky Other: _____
Are Client's parents married? Y N If divorced/separated, how old was Client when they divorced? _____ Why did they divorce/separate?_____
Who did Client grow up with? _____
Did either of Client's parents remarry? Y N, if so who/when: _____
Siblings: Brothers/Sisters, ages
_____
_____
_____
Client's relationship/s with sibling/s: None Good Bad Rocky
Other: _____

Growing up, has Client experienced or witnessed any of the following at home:

Domestic violence	Neglect	Physical Abuse	Poverty
Sexual Abuse	Verbal Abuse	Adoption	
Substance Abuse	Loss of Family Member	Mental Illness	
Divorce	Natural Disaster	Military Life/Deployments	
Medical Issues	DSS involvement	Homelessness	

Other/Explain:_____
_____
Does Client's family practice religion? Y N Details: _____
Are there any additional family stressors going on that may be contributing to Client's problems? (Financial, Marital, Illness, etc.) _____
_____

Cultural/Spiritual/Recreational History:
Cultural Identity (ethnicity, religion): _____
Describe any cultural issues that contribute to current problem(s): _____
_____
Currently active in community/recreational activities? Y N
Formerly active in community/recreational activities? Y N
Currently engage in hobbies? Y N
Currently participate in spiritual activities? Y N
If answered "yes" to any of the above, describe: _____
_____
_____

Developmental History
Was Client healthy at birth? Y N DK _____
Disabilities: None Cognitive MR Hearing Speech Sight Mobility

Did Client have any developmental delays or issues? Y N
Explain: _____
Were there any significant events or problems? Y N Details: _____
_____
How is Client disciplined? _____
Does Client consider it appropriate or abusive? _____
Do you consider it appropriate or abusive: _____
Did Client have behavior problems growing up? Explain _____
_____
Has Client received previous counseling? Y N
For: _____
Were you emancipated from your home? Y N At what age? ___
Circumstances: _____
Has Client witnessed or experienced any traumatic events? What?
_____

Did Client experience prenatal exposure to: Alcohol Tobacco Other drugs None DK

Educational/Social History
At what age did Client begin school? _____
What grade is Client in now? _____
Has Client ever repeated a grade? Y N
What school does Client attend? _____
Who is your child's Counselor? _____
Does Client like school? Y N

Do or have any of the following apply to Client?

Normal intelligence	High Intelligence	Authority conflicts
Underachieving	Attention Disorder	Speech Disorder
Mild Retardation	Moderate Retardation	Severe Retardation
Advanced/Gifted Classes	Behavior Classes	Special Education

Learning Disorder Other: _____

How does Client perform in school? Good Average Poorly Other: _____
What is Client's best subject? _____ Worst Subject? _____
What are Client's strengths? _____
What are Client's weaknesses? _____
Sports/Extracurricular activities: Y N _____
Does Client work while in school? If yes, what does Client do?_____
Has Client dated others? Y N
Has Client used drugs or alcohol? How much? Y N _____
Has Client ever been suspended/expelled? Y N_____
Has Client ever been arrested? Y N Explain: _____
How does Client get along with Client's teachers? _____

How does Client get along with Client's peers? _____
Does Client have at least one significant friendship that is not romantic? Y N
Does Client have a support system? Who? _____
Has Client ever had the same friend for more than a year? Y N
Does Client spend times with Client's friends away from Client's significant other? Y N
Who does Client consider to be Client's strongest family or social supports? None or List:
_____

How would Client describe Client's self?

_____
_____

How would OTHERS describe Client?

Friendly	Loner	Shy	Outgoing	Laid Back
Generous	Selfish	Haughty	Ugly	Happy
Type "A"	Fun	Humble	Attractive	Complainer
Picky	Mean	Argumentative		Intimidating

Other: _____

Please circle if any of the following apply to Client:
Is popular Makes friends easily Has many friends Has a friend or a few close friends
Has difficulty fitting in Stays isolated from others Is often teased
Feels awkward/shy in social situations Often feels lonely Doesn't fit in
Chooses friends I (parent/guardian) don't approve of

Legal History
Current or Pending legal issues: Y N Adult Juvenile
Details: _____
Prior legal issues: _____
Has Client ever run away from home? Y N
If so, when and what led up to the runaway? _____

Substance Abuse/Use History
***Alcohol/Drug Use: Y N Current Past**

Under the influence now	Been hospitalized	Arrests
Job Loss	DT's	Family Problems
Blackouts	IV Drug Use	Family Hx

If someone else, who? _____

Drug/s of Choice:

None	Alcohol	Marijuana	Tranquilizers
Opiates	Heroin	Barbituates	Amphetamines
PCP	Cocaine	Crack	Hallucinogen
Inhalants	Prescription Drugs	Cigarettes	Caffeine

Other: _____

Consequences of Substance Abuse:
Hangovers Withdrawal Symptoms Sleep Disturbance Binges Seizures

Medical Conditions Assaults Job Loss Blackouts Tolerance Changes
Suicidal Impulse Arrests Overdose Loss of Control Relationship Conflicts
Other: _____

In Remission: _____ Last Use: _____
Source: Street Family Friends Other: _____
At what age did Client start? : _____ How many total years? _____

Substance, Route, Age of 1st use, Routine Amount, Frequency
Route: *oral, inhale, smoking, inject, other*
Frequency: *None, remission, none in past month, 1-3x mth, 1-2x wk, 3-7x wk, daily*

1._____
2._____
3._____

Withdrawal Symptoms: Y N NA
If yes, details:
_____
_____

Have Client ever been told Client has a problem? Y N
Does CLIENT think Client has a problem? Y N
Do you or Client think Client NEEDS treatment? Y N
Is Client receptive to treatment? Y N: Inpatient Outpatient
Has Client ever been in Rehab? Y N
If yes, when, where and how long?
_____
Does anyone in Client's family have a problem with substance abuse? Y N
Details: _____
_____

Medical History
How do you rate Client's current physical health? Good Fair Poor
Does Client have a PCP that Client sees regularly? Y N
Who/where are you seen? _____
When was Client's last doctor's visit? _____
Has Client had any major illness, hospitalizations or surgeries? If yes, when, and where?
_____
_____
Please circle any of the following major illnesses that run in your family:

Tuberculosis	Heart disease	Birth Defects	High Blood Pressure
Emotional Problems	Behavior Problems	Alcoholism	Drug Abuse
Thyroid Problems	Diabetes	Cancer	Alzheimer's Disease
Dementia	Mental Retardation	Stroke	Other: _____

Is Client affected by a terminal illness: Y N :_____
Is Client currently or has Client ever been pregnant? Y N
Current Medications: (med, route, dosage, frequency, for what) NONE or list below or attach list

1. _____
2. _____
3. _____
4. _____
5. _____

How do Client's meds make Client feel? _____
Drug Allergies: NKA Type: _____

Has Client ever had any of the following? Please note the age.
Chickenpox (age _____) German Measles (age _____) Red Measles (age _____)
Rheumatic Fever (age _____) Whooping Cough (age _____) Mumps (age _____)
Scarlet Fever (age _____) Lead Poisoning (age _____) Diptheria (age _____)
Poliomyelitis (age _____) Pneumonia (age _____) Tuberculosis (age _____)
___ Mental Retardation ___ Asthma ___ Autism ___Eat infections

Allergies: _____
_____
Significant Injuries and chronic/serious health problems: _____
_____

Mental Health History
Has Client ever been treated for any mental health/psychiatric problem/diagnosis? Y N
Has Client ever been hospitalized for psychiatric reasons? Y N
If so, when and what for? _____
Previous Counseling/Therapy? Y N
Details: _____
_____
How was the experience? Very Positive Somewhat Positive Not Sure Negative
Family history of mental illnesses/issues: Y N
Explain: _____
_____

Has Client ever attempted suicide? Y N
Has Client ever talked about suicide? Y N
Has Client ever talked of killing someone else? Y N
How does Client handle his/her anger? _____
Does Client have any thoughts s/he can't stop thinking about? What? Y N
_____
Does Client have any thoughts that scare him/her? _____
Does Client see or hear things that others don't seem to see/hear? _____
Has Client ever had psychological testing done before? When/where? By whom?

Current Psychotropic Medications: (med, route, dosage, frequency, purpose, duration)
1._____
2._____
3. _____
4. _____
How do Client's meds make Client feel? _____
Who prescribes them? _____
Last appointment: _____Next appointment:_____
If none: will Client consider taking psychotropic meds if indicated by doctor? Y N

SYMPTOMS:

Please mark which of the following are considered to be a significant problem for Client (Circle). When did these start?
Difficulty remaining seated ____
Easily distracted ____
Difficulty waiting turn ____
Often blurts out answers to questions before they have been completed ____
Difficulty following instructions ____
Difficulty sustaining attention ____
Shifts from one activity to another ____
Difficulty playing quietly ____
Often talks excessively ____
Often interrupts or intrudes on others ____
Often does not listen ____
Often loses things ____
Often engages in physically dangerous activities ____
Often truant ____
Cruel to animals ____
Forced someone else into sexual activity ____
Used a weapon in a fight ____
Often initiates physical fights ____
Physically cruel to people ____
Persistent school refusal ____
Persistent refusal to sleep alone ____
Persistent avoidance of being alone ____
Repeated nightmares regarding separation from important people ____
Physical complaints ____
Excessive distress in anticipation of separation from caregiver(s) ____
Excessive distress when separated from home or caregiver(s) ____
Unrealistic worry about future events ____
Unrealistic concern about appropriateness of past behavior ____
Unrealistic concern about competence ____

Marked self-consciousness ____
Excessive need for reassurance ____
Marked inability to relax ____

Please rate how strongly Client is/has experienced the following symptoms (0 – Not applicable to 10 – I am feeling or have felt this very strongly!) and if the rating is for currently (C) or for the past (P).
Example: "Depression: 0P 9C" would mean you have felt no depression in your past but a great deal of depression currently.
Experienced Recent Loss? Y N _____
Depression: _____ Appetite: _____
Weight changes: _____ Sleep Problems: _____
Poor Concentration: _____ Isolation/Withdrawal: _____
Hopelessness: _____ Emotionality: _____
Grief: _____ Poor Grooming: _____
Anorexia: _____ Laxative/Diuretic use: _____
Dissociative states: _____ Somatic Complaints: _____
Conduct Problems: _____ Oppositional Behavior: _____
Irritability: _____ Fatigue: _____
Crying: _____ Worthlessness: _____
Guilt: _____ Loss of Interest: _____
Delusions: _____ Hallucinations: _____
Paranoia: _____ Mood Swings: ___ _____
Anxiety: _____ Grandiosity: _____
Impulsiveness: _____ Hyper/hyposexuality: _____
Hyper/Hypoactivity: _____ Talkative: _____
Compulsive beh: _____ Obsessive Thoughts: _____
Panic Attacks: _____ Excessive Worry: _____
Fears/Phobias: _____ Avoidance: _____
Flashbacks: _____ Nightmares: _____
Dissociative Episodes: _____ Perfectionism: _____
Domestic Violence: _____ Impaired Memory: _____
Frequent Lying: _____ Stealing: _____
Bingeing: _____ Purging: _____
Sexual Issues: _____ Substance Use/Abuse: _____
Fighting: _____ Promiscuity: _____
Fire Setting: _____ Running Away/desertion: _____
Property Destruction: _____ Euphoria: _____
Overspending: _____ Self-mutilation: _____
Anger Issues: _____ Repetitive Behaviors: _____
Fidgeting: _____
Other: _____

HX of Trauma: Y N
Rape Victim Witness to traumatic event
Robbery victim Physical Abuse Verbal Abuse

Sexual Abuse Victim of DV Assault Victim
TBI PTSD Shooting Victim
Natural Disaster Death of Immediate Family Member
Other: _***Additional Information:***
Strengths:
_____
_____

Deficits/Problems/Needs/Areas of Impairment to address through counseling or via referral:
Coping skills Anger management MH symptoms Community resources
Living Skills Communication Social Skills Transportation
Medications SA Treatment Couples Counseling Parenting
Self Esteem Grief Resilience Recovery
Other: _____

Other Professional Supports Currently in Place:
_____
_____

Areas of impairment: (GAF): ____ Date: _____
Marital/Intimacy/Family Academic Health Housing
Spiritual Vocational Social Leisure
Financial Safety Legal Occupational
Support System

Outstanding issues needing addressed
_____
_____
_____

Ethnic/ Cultural/Individual Considerations:
_____
_____
_____

MH Service/Referral Recommendations:
Details:
_____
_____
_____

Part 2: For Counselor and/or Minor Client to complete

What do you like to do…

What do you like to do for fun?

What do you most like to do with your mom?

What do you most like to do with your dad?

What do you most like to do with your friends?

What is your favorite television show?

What is your favorite book?

School

What is your favorite subject in school?

What is your least favorite subject in school?

What do you most like about your teacher?

What would you most like to change about school?

What do you want to do when you finish school?

Do you get along well with your teachers? Peers?

Do you get bullied? Have you ever been bullied?

Home
Who lives at home with you?

Do you have your own room?

Are your family members healthy?

What do your parents do for a living?

How do you get along with your parents and siblings?

If you could change anything you would like about your family, what would you change? Why?

Is there any violence in your home? Does it ever get physical?

In Trouble…
What do you get into trouble for at home?

How do your parents discipline you?

What do you get into trouble for at school?

Wishes…
If you could have three wishes come true, what would you wish for?
1.
2.
3.

Changes…
What would your most like to change about yourself?

If you could tell your dad to stop doing one thing, what would it be?

If you could tell your mom to stop doing one thing, what would it be?

Friends…
Who are your friends at school? What are they like?

Do you see them outside of school?

Who are your friends in the neighborhood?

Have you ever been in a relationship? When? What was it like?

Have you ever had sex? How many partners have you had? Did you use contraception?

Worries…
When you worry, what do you worry about?

Anger…
What makes you angry?

What do you do when you get angry?

Strengths and Weaknesses
What are three things you are really good at?
1.
2.
3.

What are three things you are not so good at?
1.
2.
3.

Views of Others…
Who thinks you are a really neat kid?

Who thinks you are not a neat kid?

Areas to Check Into…
Do you have any problems sleeping?

Do you have any problems eating?

Do you practice safe transportation practices? (Seatbelt? Helmet? Etc)

What do you like and not like about your body?

Have you gained or lost weight?

Have you ever tried to kill yourself?

Do you feel like killing yourself now?

Do you ever see things other people don't seem to see?

Have you ever been physically or sexually abused?

Happiness…

When do you feel really happy?

What are you doing when you feel happy? With whom?

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FOR COUNSELOR INTERVIEW ONLY

Mental Status: **Competent: Y N**

***Orientation/ Sensorium**

Person Place Time Situation

Short Term Memory: BALL ORANGE CAR

***Brief Physical Description/Appearance:**

General	Height	Posture	Weight	Age
Appropriate	Average	Relaxed	Average	Normal
Well-groomed	Short	Stiff	Underweight	Older
Poor Hygiene	Tall	Slouched	Overweight	Younger

Other: _____

***Attitude**

Appropriate	Passive	Passive/Aggressive	Reserved
Cooperative	Resistant	Belligerent	Guarded
Negative	Hostile	Sarcastic	Resentful
Suspicious	Manipulative	Tense	Arrogant
Immature	Other: _____		

***Motor Activity**

Unremarkable	Restless	Pacing	Tremulous
Hyperactive	Motionless	Tic	Fidgety

Other: _____

***Affect**

Appropriate	Happy	Bland	Labile
Restricted	Agitated	Subdued	Flat

Other: _____

***Mood**

Appears Stable	Confused	Apathetic	Fearful
Anxious	Euphoric	Depressed	Angry
Tearful	Other: _____		

***Thought/Speech**

Normal	Repetitive	Rambling	Slurred
Flight of Ideas	Tangential	Disorganized	Mumbled
Paranoid	Psychotic		

Other: _____

***Cognitive**

Normal	Overly Concrete	Failed to grasp nature of questions
Easily Distracted	Poor Abstract Thinking	Indecisive
Impressionable	Other: _____	

Long Term Memory: Intact Difficulties: Mild Moderate Extreme

***Recall: BALL ORANGE CAR**
Short Term Memory: Intact Difficulties: Mild Moderate Extreme

***Insight**
Good Average Poor

HAS CLIENT HAD PAST OR CURRENT THOUGHTS OF HARMING CLIENT'S SELF OR ANOTHER? Y N

***Danger to self or others**

None	Family HX of suicide	Suicidal/Homicidal ideations
Accident Prone	S/H Plans	Probable High Risk
Supervision available	Has Crisis plan	Needs Crisis/Safety Plan

Plans of suicide/homicide: _____
Recent suicidal attempts: _____
Past suicidal attempts: _____
Hx of assault/homicide: _____
Hx of self injury: _____
Hx of hurting an animal: _____

Additional Information:
Does Client currently practice religion/spirituality? Y N Details:
_____
Strengths:
_____
_____

Deficits/Problems/Needs/Areas of Impairment to address through counseling or via referral:

Coping skills	Anger management	MH symptoms	Community resources
Living Skills	Communication	Social Skills	Transportation
Medications	SA Treatment	Resilience	Recovery
Self Esteem	Grief		

Other: _____
Other Professional Supports Currently in Place:
_____
_____

Areas of impairment: (GAF): ____ Date: _____

Relationship/Intimacy/Family	Academic	Health	Housing
Spiritual	Vocational	Social	Leisure
Financial	Safety	Legal	Occupational
Support System			

Outstanding issues needing addressed

_____
_____
_____

Ethnic/ Cultural/Individual Considerations:

_____
_____
_____

MH Service/Referral Recommendations: Counseling Referral Medication, etc.
Details:

_____
_____

This assessment is based on information collected from the following sources:

_____

My interview with the following:
____ Patient
____ Family Members: _____
____ Friends: _____
____ Others: _____
____ Review of records (Specify): _____
____ Other sources: _____

Individual Risk Reduction Factors and Individual Risk Factors: *For hospitalized patients, this should include an assessment of the risk of elopement.*

Clinician's Formulation of Risk: *using the risk factors and risk reduction factors identified above, describe your estimation of the consumer's imminent and long term risk for suicide as well as necessary interventions to assure consumer's safety and facilitate stabilization. Describe your clinical reasoning in details.*

Interventions: *Document interventions which directly address mitigating those risk factors which are identified and can be addressed either clinically or with the help of natural supports. For consumers where a formal crisis plan is developed, that may serve to complete this section by attaching a copy of that plan.*

Any Other Special Needs of Client: *Is there anything to take into consideration when developing a treatment plan for the Client?*

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Treatment Planning

In order of significance, what issues does Client WANT to focus on in therapy?

_____
_____

What are Client's expectations for therapy? When will Client know that Client made progress or is ready to terminate?

_____
_____
_____

What information/referrals or other assistance would Client like us to provide Client with, if possible?

_____
_____

What or who is Client's best source of support/comfort?

_____

Other information not addressed above:

_____
_____

Releases Needed:

_____
_____

Tx Goals Identified by Therapist:

_____
_____
_____

END INTERVIEW HERE

If this format will be used/filed as a completed comprehensive psychological evaluation, do not write in margins. Place misc information and notes on the back.