Bio-Psycho-Social Assessment (if client is a minor)
Victor Manocchio, MSW, LCSW
6 Sunnyside Road, Tunkhannock, PA 18657
570-836-7777
NPI # 1487828554

I. Child and Home

Name: ____________________________ Date of Birth__________________ Age ____
Social Security Number: ____
Name and d.o.b. of primary insured (if different) _____________________________
Address ____
Phone Number(s) ____
____
Emergency Contacts and Phone Numbers ______________________________________

EAP? Circle one: yes or no. Authorization Number ______________________________
Health Insurance _______________________Subscriber Number __________________
Name of Primary Insured_________________________ d.o.b._____________________
Address of Primary Insured (if different than child) ___________________________
Authorization Number (if required) ____
Phone number for Mental Health (found on back of card) __________________________

SECTION (A)

Please fill in the following table: Who lives in the home?

Name	Relationship to the Child	Date of Birth	Highest level of Education

Parents or Legal Guardians: ____
Who has legal custody? ____
Is there a court order (please provide this office with a copy)? _____________________
Relationship to child or child: ____

If any of the following are present in the home, please state that and skip the section:
Biological Mother's Name: ____
Date of Birth___________ Address ____
Does she see the child? If yes, how often? ____
When was the last time she saw the child? ____

If "Mom" if different from the Biological Mother, Name?:________________________

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Date of Birth___________ Address ____
Does she see the child? If yes, how often?___________________________________
When was the last time she saw the child? ___________________________________

Biological Father's Name:____
Date of Birth___________ Address ____
Does he see the child? If yes, how often? ___________________________________
When was the last time he saw the child? ____________________________________

If "Dad" if different from the Biological Father, Name?: ________________________
Date of Birth___________ Address ____
Does he see the child? If yes, how often? ___________________________________
When was the last time he saw the child?____________________________________

II. Strengths Assessment – Child and Family

What are your strengths?____
____
____

What are the family's strengths? ____
____
____

Is there extended family support? Describe: _______________________________
____

Describe the importance of spirituality (relationship with Creator) and/ or religion (institution) in your life and family (if any): ____
____
____

Describe any cultural/ ethnic factors which may impact on treatment: _______________

III. Presenting Problem

Please state why you are seeking mental health services. (i.e., Why are you here?)_____
____
____
____

What areas of the child's life is this problem affecting?___________________________
____
____

How long have these issues been present (weeks, months, years, whole life)? _________
____

Has the child ever received services anywhere before? ___________________________
If so, where (include dates and length of service)? _____________________________
____
____

Was it helpful?____
____

Are there any other agencies/ services involved with the child at this time? ___________
Are there any community support groups (church, sports, boy scouts, youth group, Methodist Women's Association, Alcoholics Anonymous, etc.) ___________________________________

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Please list those events, situations, and problems that are causing stress for the child and his/ her family.

How have you tried to resolve the problem prior to coming here?___________________

Why are you seeking help at this particular time?________________________________

What has changed (if applicable) that the child (or child's family) needs help? ________

Suicidal Ideation? (If so, plan, seriousness?) ___________________________________

Homicidal or Suicidal thoughts? ____

History of homicide/ suicide attempts? ______________________________________

Has the child ever been hospitalized before for mental health reasons?_______________

If so, how many times, and what were the circumstances?______________________________________

IV. Family or Marital History

Are the parents married? ____

Describe the current relationship between the child's parents (as a married or committed couple).

Describe the relationship between the parents and the children.____________________

Describe the relationship between the child and their siblings (or between the children in the house)

Regarding the relationship between the parents:

The strengths of this relationship: ____

Needs or Concerns in this relationship:____

History of Domestic Violence (verbal or physical) in any of your relationships? _______

Communication Problems (past and present)? __________________________________

How many times have the parents separated and gotten back together with each and/ or with your current partner? ____

Briefly describe the average argument you have with each other and/ or your current partner:

V. Socio-Economic Data: Without telling me how much you make, please pick one of the following options that may describe your current financial situation. (Put an "X" at the appropriate choice.)

___ 1. I am not worried about my bills. I have more than enough to meet my needs each month.

___ 2. I am not worried about the bills. However, paying for everything is a little tight.
___ 3. I am barely scraping by. My family has to be creative in order make sure we have the basics.
___ 4. Our basic needs are barely met. I am thinking about declaring bankruptcy. I feel like we will have to do "macaroni and cheese" every night for a while, so that we have food on the table.
___ 5. I am in danger of losing everything, including our house. I am desperate to some way to provide for my family.

VI. Trauma and Abuse

Has the child ever been the victim of, or is suspected to be the victim of abuse (physical, sexual, or emotional) or neglect? Please explain: ____

____

____

Has the child ever been accused of being the perpetrator of abuse, neglect, or domestic violence?

____

Has the child ever experienced any other traumas (experiencing or witnessing domestic violence, serious illness, death of a loved one, being kidnapped, held hostage, threatened with weapons, victim of stalking, witnessing a murder, a fire, 9/11/01, etc.)? Please explain:__________________

____

____

____

Did the child react to this trauma with a sense of fear, helplessness, or horror to this traumatic event? (This may be exhibited in younger children by disorganized, agitated behavior): ________

____

Did the child react to the trauma by spacing out: blank, frozen, numb expression/ reactions; excessive daydreaming, or excessive preoccupation with fantasy?______________________________

____

____

Did the child deny or downplay the impact of a severe trauma and/ or did the child avoid thoughts, feelings, conversation, activities, places, or people that arose recollection of the trauma?

____

Does the child experience psychological panic or anxiety when reminded of the trauma and/ or physical upsets (headaches, stomach, etc.) at reminders of the trauma?________________________

____

____

Does the child experience low self-worth (self-esteem), at reminders of trauma? ________

____

____

Does the child exhibit inappropriate sexualized behavior, excessive aggression, or separation anxiety after exposure to this trauma? ____

____

____

VII. Drugs and Alcohol (Addictions):

Does the child/ family members smoke? How much?______________________________

____

____

Does the child/ family drink alcohol? How much and how often? ___________________

____

Does the child/ family members use drugs (illegal, over-use of prescribed, or non-prescribed, etc.)? If so who? What Drugs? How much and how often? ____________________

Does the child/ family members gamble? If so, expound: ____________________

Have you/ family members ever received Drug and Alcohol Treatment? (rehab, I.O.P., outpatient, etc.)

VIII. Military Background

Has the family ever served in the military? ____________________
What branch? ____________ What rank? ____________
How many years and where did they serve? ____________________

Any combat seen? ____________________
How were they discharged? Honorable/ Dishonorable? ____________________

Other comments: ____________________

IX. Medical Background.

Current Medications, Vitamins and Supplements (Topical and Oral):

Name of Medication	Dosage	How many times per day?	Prescribing Physcian

General Health Status: ____________________
Name address phone of family doctor: ____________________

When was your last physical exam? ____________________
In the past 6 months, any changes in sleeping patterns? ____________________
How many hours (average) of sleep does the child get per night? ____________
History of Chemical Dependence/ Drug use? ____________________
Allergies: ____________________
Any neurological disorders? ____________________

Any known Intellectual Deficits and Disabilities (formerly known as Mental Retardation)?
Vision or Hearing Impairment? ____________________

Present/Past Significant Illnesses or Injuries and Treatment Received: ____________

Impact on life/ family ____________________

Physical Limitations: ____

____

____

Past Surgeries/Hospitalizations and Dates ____

____

____

Pain Assessment:
Does the child complain of pain or appear to be experiencing pain? ___ No ___ Yes If yes, recommended follow up: ____

____

Nutrition Screen:
Is the child on a special diet? ____
Any changes in appetite? ____
Is there any history of eating disorder? ____
Has anyone suspected you of having an eating disorder? _____________________________
Has the child had any significant weight loss/ gain, or changes in eating habits? ________

____

____

Does the child appear underweight/ over weight? ___________________________________

____

X. Family Mental Health History
Is there a family history of mental illness [i.e., mood problems, schizophrenia, psychosis, or problems with attention, activity and impulse (especially as a child)]? If so, please explain. ______

____

Any known Intellectual Deficits and Disabilities (formerly known as Mental Retardation)?

XI. Social History
How does the child interact with others? ____

____

____

Describe any needs or concerns in this area: ______________________________________

____

____

What does the child do in his/ her leisure time? ___________________________________

____

____

How many hours (average) does the minor use electronics (TV, computer, xbox, playstation, handhelds, etc.)?

Other Stressors:
Has the child ever been a victim of hate crimes? ___________________________________

____

Any involvement in or exposure to school/work/community violence? _______________

____

Has the child ever been threatened physically with weapons/ held captive/ held hostage?

____

Has the child had any losses, deaths , moves (especially in the past five years)? ________

____

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____

Educational History

Name of School___________ School District____________________ Grade __________
Have supports in school (Gifted, Learning, Educational)?___________________________
Academic performance - above, average, below, failing? ___________________________
Days Tardy _____.Days Absent _____ Visiting Nurse how often? ____________________
Problems in school? Discipline Issues? ____
____

Legal Problems? (Current and History – if applicable, complete table) ______________
____

Date of Arrest	Charge	Sentence	Probation	Date released

Other stressors: ____
____

Sexual History (if age appropriate):
What is the child's primary sexual orientation?
___Heterosexual - (i.e. straight) ___ Cis-gender (same as birth)
___ Homosexual - (i.e. gay) ___ Transgender (different from birth)
___ Bisexual If not cis-gender, preferred pronoun? _______
Are there other sexual orientation/ gender identity issues that should be noted? __________
____
If appropriate, at what age did the child become sexually active? ___________________
Age entered puberty?____
Marital status? ____
Does the minor have any children? _____________________________________
Where do the children live?____
____
If female, how many miscarriages and abortions, if any? When? ___________________
____
Are there any other sexual history/ issues that should be noted? ___________________
____

Is there any thing else that I should know about? ______________________________
____
____

XII. Goals

What do you hope to gain from these sessions in:

(A) One month ____
____
(B) Three months ____
____

(C) Six months ____

What is your long-term goal for treatment? ______________________________

____

____

Please read the following and sign:

We accept cash, personal checks, credit cards (MC, Visa, American Express, Discover), FSA and HAS debit cards. Please note there is a 4% convenience fee for using credit and debit cards.

We require 24Thour notification for cancelation of appointment. A fee of $60 will be assessed for all no-shows and all cancelations made with less than 24Thour notification. Future appointments will not be made until account is brought current and this fee is paid in full or payment arrangements are made.

Please initial the following:

I understand that fee is due at time of service: ___________

I understand that there is a 4% convenience fee for using credit and debit cards: _____________

I understand that there is a $60 fee for all *no-shows* and appointments canceled with less than 24-hours notice and that future appointments will not be made until this fee is paid in full: _____________

I understand that there is a $50 service fee for all returned checks: ____________

Patient signature ____ Date ___________________

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Assessment of Child and Family History (OFFICE USE ONLY)

DIAGNOSIS:

AXIS I: ____________________

AXIS II: ____________________

AXIS III: ____________________

AXIS IV: ____________________

AXIS V: ____________________

____________________ ____________________
Victor J. Manocchio, LSW Date