AMISTAD FAMILY SERVICES, INC.

3100 Oak St. Las Cruces, NM 88005
www.afsnm.com ♥ (575) 523-2288 phone ♥ (575) 523-2299 fax

BIO-PSYCHO-SOCIAL ASSESSMENT

IDENTIFYING INFORMATION

Referral Source: ☐ Self ☐ Schools ☐ CYFD ☐ Court Ordered ☐ Physician ☐ Internet ☐ Other:		
Client Legal Name:	Date of Birth:	Do you identify as: ☐ M ☐ F ☐ GNC
Preferred Name:	Primary Language:	Religion:
Client Address:		Zip Code:
Race/Ethnicity: ☐Anglo ☐ Latin-X ☐ Native American ☐ African American ☐ Asian ☐ Other:		
Client is: ☐ Minor Child ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered		

EMERGENCY CONTACT

Name: _____ Phone #: _____

Relationship to client: ☐ Parent ☐ Spouse / Significant Other ☐ Friend ☐ Other _____

WHY ARE YOU SEEKING SERVICES

Please explain why you are seeking services:

Are there any specific events or stressors that you would like your therapist to know about?

RISK FACTORS

Have you, the client, been abused					
Emotionally?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Physically?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Sexually?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Have you, the client, been abusive to someone else					
Emotionally?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Physically?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Sexually?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Has your family had Child Protective Services Involvement?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Do you, the client, or any close family members have					
Criminal History?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Probation History?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Legal Difficulties?	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Neglect	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Domestic Violence	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Is the client sexually Active	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Family Conflict	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Comments or details:					
Homelessness	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Homicidal	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Details including date(s), Method(s) and lethality:					

Suicidal Ideation	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Details including date(s), Method(s) and lethality:					
Academic Performance Issues	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Cutting	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Developmental Delays	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Difficulty Paying Attention	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Sensitive to Touch, Sound, Light, Motion	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Loss of a Loved One	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No

MEDICAL HISTORY

Condition:	When:
Treatment:	
Condition:	When:
Treatment:	
Condition:	When:
Treatment:	
Allergies and reactions:	
Notes:	

PAST PSYCHIATRIC HISTORY

Prior treatment: Yes ☐ No ☐	Where:	Diagnosis:
Hospitalization: Yes ☐ No ☐	Suicide Attempt: Yes ☐ No ☐	Violence History: Yes ☐ No ☐
Notes (including family history):		

CURRENT MEDICATIONS

Medication:	Dose:	Prescribing Physician:
Purpose of medication:		
Medication:	Dose:	Prescribing Physician:
Purpose of medication:		
Medication:	Dose:	Prescribing Physician:
Purpose of medication:		
Other:		

SUBSTANCE USE INCLUDING TOBACCO / NICOTINE PRODUCTS

Alcohol: Yes ☐ No ☐	What age did you start:	Frequency:
Other Substances: Yes ☐ No ☐	What:	
What age did you start:	Frequency:	Last use:
Other Substances: Yes ☐ No ☐	What:	
What age did you start:	Frequency:	Last use:
Notes (including family history):		

EMOTIONAL/EDUCATIONAL/OCCUPATIONAL HISTORY

Please describe individuals that live in your household:

First and Last Name	Date of Birth	Relationship to Client	Highest Level of Education	Description of Relationship (i.e. positive, stressful, cut-off, etc.)

Please describe any birth parents and/or siblings not living in the child's current home:

First and Last Name	Date of Birth	Relationship to Client	Highest Level of Education	Description of Relationship (i.e. positive, stressful, cut-off, etc.)

Please describe any relationships with friends or family that you feel are important to share with your therapist:

What are your / your child's personal strengths:

Any stressors at or about school or work affecting you / your family:

Are there any community support services being utilized by your household at this time?
☐ WIC ☐ Snap ☐ TANF ☐ Medicaid ☐ Housing Assistance ☐ Child Care Assistance ☐ Head Start
☐ Other: _____

Do you feel there are any limitations or barriers to you seeking services?

GENERALIZED ANXIETY DISORDER SCALE (GAD 7)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Clinician Use: Score	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)				
Over the past 2 weeks, how often have you been bothered by any of the following problems	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching tv	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Clinician Use: Score

PHQ-A EXTENDED QUESTIONS FOR CHILDREN AND ADOLESCENTS

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with others?
☐ Not at all difficult ☐ Somewhat difficult ☐ Very difficult ☐Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

If the client is not a minor child, you may skip to the signature page.

ADDITIONAL MINOR CHILD INFORMATION

What is your child's living/custody arrangement (check all that apply)?

☐ Birth Mother ☐ Birth Father ☐ Guardianship ☐ Foster Care ☐ Adoptive Family ☐ Step Mother ☐ Step Father
☐ Other (explain): _____

Primary Guardian: _____ Phone: _____

If parents are not together who has legal rights to consent for treatment? _____

Is there a Parenting Plan or court documentation? ☐ Yes ☐ No (If yes, please provide a copy for your client file).

Is there another person who is legally required to consent to your child's treatment? ☐ Yes ☐ No

If yes, who: _____ Phone: _____

Address: _____
Street State Zip Code

Is the Child Placed out of the Biological Parents' Home? ☐ Yes ☐ No If yes, please explain:

Current Guardian (If other than biological parents): _____

Address: _____
Street State Zip Code

PREGNANCY & BIRTH

□ Check if birth history is not known

How many times was the mother pregnant before this child? ____

Any: Miscarriages? ☐ Yes ☐ No If yes, how many ____ Stillbirths? ☐ Yes ☐ No If yes, how many ____

At the time of birth, how old was Mother: _____ Father _____

Any problems during pregnancy? ☐ Yes ☐ No If yes, please explain:

During pregnancy, did mother take:

Prescription Medications? ☐ Yes ☐ No If yes, explain: _____

Vitamins / supplements? ☐ Yes ☐ No If yes, explain: _____

Drugs? ☐ Yes ☐ No If yes, list: _____

Smoke / Vape? ☐ Yes ☐ No If yes, how much per day? _____

Drink alcohol? ☐ Yes ☐ No If yes, how much?: _____

Fertility Assistance? ☐ Yes ☐ No If yes, explain: _____

Was the child born on time? ☐ Yes ☐ No Number of Weeks? ____ Birth Weight: _____

Was the child born: □ Naturally (vaginally) □ C-Section □ Induced / forceps / vacuum

If C-section or induction, why? _____

Problems during delivery? ☐ Yes ☐ No If yes, explain: _____

Was this a □ Home or □ Hospital birth? If hospital birth, how long was the hospital stay? _____

Did this child have any medical problems after birth?

□ Breathing Problems □ Heart Problems □ Brain Problems □ Eye Problems

□ Feeding Problems □ Infections □ Stomach Problems □ Skin Problems

□ Other:

Did any of these problems require extended hospitalization? ☐ Yes ☐ No

If yes, explain:

Was the child: Breast feed? ☐ Yes ☐ No If yes, How long? _____ Bottle fed? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

□ Check if developmental history is not known

At what age was the child able to do the following (you may use "early", "on time" or "late" if age is unknown

Roll over _____ Crawl _____ Sit alone _____ Stand alone _____ Walk alone _____

Smile _____ Coo/Babble _____ Single words _____ Phrases _____ Short sentences _____

Feed self _____ Dress self _____ Toilet trained: Bowel _____ Bladder _____

Are you concerned about your child's development / behavior? ☐ Yes ☐ No If yes, explain:

Does the child prefer to play (mark all that apply) ☐ Alone ☐ with other children

☐ with all ages ☐ with same age children ☐ with younger children ☐ with older children

Do you have any concerns about your child's social or play skills? ☐ Yes ☐ No If yes, explain:

EDUCATIONAL HISTORY

Does the child attend school? ☐ Yes ☐ No If yes, what type(s) of classroom: (check all that apply)

☐ Daycare ☐ Head Start ☐ Structured Preschool ☐ Regular and special classes ☐ Regular classroom

☐ Home school ☐ Special classes (describe) _____

What School does the child attend? _____

Name: _____ DOB: _____

Does the child have an Individualized Education Program (IEP) ☐ Yes ☐ No If yes, explain:

Does the child have a 504 plan? ☐ Yes ☐ No *If yes, please provide a recent copy if available*

Does your child receive any special services at school? (check all that apply)

☐ Physical therapy ☐ Occupational therapy ☐ Speech/language therapy ☐ Vision impaired ☐ Hearing impaired

☐ Adaptive PE ☐ Bus / transportation services ☐ Resource room / special instruction

☐ Other: _____

THERAPY / SERVICES HISTORY

Has the child received Early Intervention (EI) services? ☐ Never ☐ Past ☐ Current (please list)

Service Type	Location	How long

SIGNATURE

_____ _____

Client, Parent/Guardian's Signature Date

Amistad Family Services, Inc. hours of operation are Monday – Friday from 9:00 am -5:00 pm excluding major Federal Holidays. Evening, weekend and holiday hours may be available by appointment and vary per provider.

FOR PROVIDER USE: INITIAL DIAGNOSIS

Initial Diagnosis/ICD-10 Code: _____ / _____

Treatment Recommendations:

Intake Notes:

_____ _____

Clinician's Signature & Credentials Date