Florida Palms Academy, Inc.

Parent BioPsychoSocial Assessment

Name of person completing this assessment and Relationship to the child:

____

Child's Name:____________________________ Birth Certificate Provided? Y N
Date of Birth: ____________________________
Social Security #: _________________________ Social Security Card Provided? Y N
Medicaid #: ______________________________ Medicaid Card Provided? Y N
Who is the child's primary caregiver and legal guardian? (name, occupation, relationship):
____
Address: __________________________________
____
____
Phone: Home ________________________Cell________________________ Fax ___________________
Email: ____

Is the child in the care of family? Y N
Is the child in foster care? Y N
Is the child adopted? Y N Were the adoption papers provided? Y N

Where was the client born? _________________________
Height: _____________Weight: _______________Hair color: _______________ Eye Color: ________
Was the child last physical completed within 30 days of admission? Y N Date: __________________
Was a Yellow for Provided? Y N
Are all the child's immunization records up to date? Y N Was a Blue Form Provided? Y N

Birth / Milestones:
Weeks: _________ Height: __________ Weight:___________ Delivery: Vaginal or Cesarean
Substances used during pregnancy? Y N If Yes, Explain: ___________________________________
Prenatal care? Y N
Age when child: Walked:_____ Talked:______ Toilet Trained? ______

Parental Information:

Biological Mother's Name:______________________ Age: ____ DOB_____Occupation:___________
Does child reside with parent? Y N Parent Whereabouts: ______________________________
Mental Health Issues? Y N Explain: ____
____
Taking Psychotropic Medications? Y N What? ____
Substance Abuse History? Y N Explain: ____
Criminal History? Y N Explain: ____

Biological Father's Name:______________________ Age: ____ DOB____Occupation:____________
Does child reside with parent? Y N Parent Whereabouts: ______________________________
Mental Health Issues? Y N Explain: ____
____
Taking Psychotropic Medications? Y N What? ____
Substance Abuse History? Y N Explain: ____
Criminal History? Y N Explain: ____

Step/Adoptive Mother's Name:____
Age: _______ DOB ___________Occupation:____
Does child reside with parent? Y N Parent Whereabouts: ____________________________
Mental Health Issues? Y N Explain: ____
____
Taking Psychotropic Medications? Y N What? ____
Substance Abuse History? Y N Explain: ____
Criminal History? Y N Explain: ____

Step/Adoptive Father's Name:____
Age: _______ DOB ___________Occupation:____
Does child reside with parent? Y N Parent Whereabouts: ____________________________
Mental Health Issues? Y N Explain: ____
____
Taking Psychotropic Medications? Y N What? ____
Substance Abuse History? Y N Explain: ____
Criminal History? Y N Explain: ____

Siblings: (include half and step siblings - complete what information is known)

Name: _____________________ Age: _____ DOB______ Gender: M F Live with child? Y N
Mental Health Issues? Y N If Yes, Describe: ____

Name: _____________________ Age: _____ DOB______ Gender: M F Live with child? Y N
Mental Health Issues? Y N If Yes, Describe: ____

Name: _____________________ Age: _____ DOB______ Gender: M F Live with child? Y N
Mental Health Issues? Y N If Yes, Describe: ____

Name: _____________________ Age: _____ DOB______ Gender: M F Live with child? Y N
Mental Health Issues? Y N If Yes, Describe: ____

Name: _____________________ Age: _____ DOB______ Gender: M F Live with child? Y N
Mental Health Issues? Y N If Yes, Describe: ____

Name: _____________________ Age: _____ DOB______ Gender: M F Live with child? Y N
Mental Health Issues? Y N If Yes, Describe: ____

Name: _____________________ Age: _____ DOB______ Gender: M F Live with child? Y N
Mental Health Issues? Y N If Yes, Describe: ____

Substance Abuse History:

1. Does the child use any illegal substances / alcohol/ tobacco? Y N
   Please explain in detail: ____
   ____
   ____
   ____
   ____

Physical/Sexual Abuse History:

1. Was the child ever physically abused? Y N
   By Who?_______________ When? ________________ Incident/Outcome: _________________
   ____
   ____
2. Was the child ever sexually abused? Y N
   By Who? _______________ When? ________________ Incident/Outcome: _________________
   ____
   ____

Legal / Criminal History:

1. Has the child ever been arrested? Y N Reason(s)______________________________________
2. Are there any open charges pending? ____
3. Is a DJJ advocate/worker assigned to the child? Y N If so, please provide the worker's name, address, and phone____
4. Are there any specific court orders the child is to follow? Y N (Include No Contact Orders, Restraining Orders, Child Custody Orders, etc. in addition, provide the facility with a copy)
   ____
   ____

Educational History:

1. What school does the child currently attend? ________________ Grade? ______________
2. Does the child receive any special services? Y N Explain: ______________________________
   ____
3. Has the child ever repeated any grades? Y N Which grades and why? _____________________
   ____
4. Does the child have a current IEP? Y N What are the listed Eligibilities? __________________
5. Was a copy provided to the facility? Y N
6. What are your educational goals for the child? ____
7. Was a SED / NET referral ever made on the child? Y N When? _____________________
   Status: ________________________

Medical History:

1. Does the child have bedwetting issues? Y N
   If Yes, what age after being potty trained did it start? ______
   How often does it occur? ____________________________
   Has the child seen a doctor for this? Y N If so, what is the outcome? ____________________
   ____
2. Does the child have any known allergies? Y N If Yes, Please list to what and the reaction
   ____
   ____
   ____
3. Date of last Eye Exam: _________________ MD name and phone:________________________

Does the child wear eye glasses? Y N **If Yes, please bring them to the program.**
Do they need them to read? Y N

4. Date of last Dental Exam: _______________ MD name and phone:_________________________

5. Does or has the child seen a Neurologist? Y N If yes, When? ___________________________
   What was the reason? ____
   MD name and phone:____

6. Does or has the child seen a Cardiologist? Y N If yes, When? ___________________________
   What was the reason? ____
   MD name and phone:____

7. Does or has the child seen an Endocrinologist? Y N If yes, When? ______________________
   What was the reason? ____
   MD name and phone:____

8. Does or has the child seen an Orthodontist? Y N If yes, When? __________________________
   What was the reason? ____
   MD name and phone:____

9. Does or has the child seen a Orthopedist? Y N If yes, When? ___________________________
   What was the reason? ____
   MD name and phone:____

10. Has the child even been seen for Genetic Testing? Y N If yes, When? ____________________
    What was the reason? ____
    MD name and phone:____

11. The last time the child has seen a Pediatrician? ____
    MD name and phone:____

12. Date of last EKG: ________________ Reason: ________________Results: __________________

13. Date of last Labs: ________________

14. History of Diabetes? Y N Treatment/MD information:_________________________________

15. History of Asthma? Y N Treatment/MD information:__________________________________
    If Yes, does the child use an inhaler? Y N Nebulizer? Y N *** **Please provide all medications, nebulizer and its parts to the facility upon admission.**

16. Is there any other noteworthy medical information the facility should be aware of? __________
    ____

Religious/Spiritual Preferences:

Religious Background? _______________________________________
Attend Church? Y N Where? _________________________

Cultural Preferences:

Explain: ____
____
____

Treatment History:

Baker Acts / Voluntary Psychiatric Admissions: (list in chronological order, most recent first)

Hospital	Date Admitted	Date Discharged	Reason for BA	Outcome/plan

Important information to note: ____
____
____

Community Based Services: (list in chronological order, most recent first)

Type of Service	Agency	Therapist	Date Started	Date Ended	Outcome

Medication: (List all medication the child has **ever** been on, starting with current medications first)

Please be VERY SPECIFIC!!!!

Medication	Dosage	Date Started	Date Stopped	Prescribing Physician and Agency	Side Effects?	Reasons for stopping?

Psychological History:

1. Has the child had any psychological testing performed? Y N
2. Copy provided to facility? Y N
3. What is the child's Full Scale IQ? ______________ Date of evaluation? _____________________

General Questions Related to the Client and Behaviors:

What are the specific behaviors the client has demonstrated which require treatment and services?

____
____
____
____
____

How has the child's behaviors / condition affected his / her family system?

____
____
____
____
____

Describe the last incident in which the client's negative behaviors required intervention, including how the incident started, client's behaviors, length of incident, and how the incident was resolved.

____
____
____
____
____
____

In the past, what types of interventions have been effective in calming the client after he/she becomes agitated?

____
____
____
____
____

What is the child's discharge plan? (Where will the child be returning to live, what services are thought to be needed, etc.)

____
____
____
____
____

What are your goals for the child?

____
____
____
____
____

What are your goals as a parent?

____
____
____
____
____

What are the child's strengths? ____
____
____

What are the child interests / hobbies?____
____
____

<u>Important Name and Phone Numbers:</u> (include all family and providers working with the client)

Name (first and last)	**Relationship**	**Phone Number**	**Address (if health care provider)**	**Permitted to contact child?**

Create a password for the child in regards to calling in or visiting: ______________________________
(This is a password only the callers / visitors should know, not the child)