The Charis Center for Eating Disorders
Indiana University Health

Adolescent Biopsychosocial Form

Please complete this form. The following pages may be completed by the parent or caregiver of patient.

Patient's legal name_____ Nickname: _____Date of birth_____

Information given by: ___Self _____Other (name of person/relationship)

Gender _____ Pronouns_____ Primary spoken/written language_____

Race (American Indian, Alaskan Native, Asian, Black or African American, Hispanic, Native Hawaiian or Pacific Islander, White, other)

_____ Ethnicity (nationality) _____

Legal guardian name: _____

Legal guardian relationship to patient ___mother ____father ___foster father ____foster mother ____sibling

___grandfather ___grandmother ____sibling ____spouse ____stepfather ____stepmother ____step sibling ____other

Barriers to communication? ___None ___Language ___ Hearing ___ Visual ___ Cognitive___ Speech___ Other_____

Physical disabilities or physical challenges? ___None ___Yes (please describe) _____

Presenting problems

Reason for coming to treatment at this time _____

_____

Onset age of disordered eating behaviors _____ Triggering events influencing disordered eating? _____

_____

Attempts to resolve disordered eating _____

What are the patient's goals for coming to The Charis Center for Eating Disorders?

_____

What is the patient's motivation to meet the goals? _____

Barriers to treatment? ___No ___Yes _____

Behavioral Concerns

Please read each item carefully. If an item applies to the patient, please check the box yes or no next to the item.

Behavior	Yes	No	Behavior	Yes	No
Trouble Hearing			Overly Sensitive to Sounds		
Visual Problems			Tilts Head to Look at Items		
Daytime Toileting Accidents			Nighttime Toileting Accidents		
Poor Eye Contact			Does Not Play Well with Other Peers		
Difficulty with Change in Routine			Very Sensitive to Textures		

Stares into Space/ Seems in a Trance			Easily Frustrated		
Frequent Tantrums			Rarely Smiles or Laughs		
Eats Non-Food Items			Aggressive Toward Animals		
Runs Away from Home			Shoplifting, Stealing		
Frequent Lying			Rapid, Intense Mood Swings		
Frequent Outbursts			Significant Weight Change		
Appetite Fluctuations			Declining School Grades		
Refusal to Attend School			Paranoid Thoughts		
Reoccurring Motor Movements			Reoccurring Vocalizations		
Loss of Interest in Prior Activities					

Medical History

Patient's Primary Care Physician Name _____ Phone _____

Medical Specialist Physician Name _____ Phone _____

Previous Therapist Name _____ Phone _____

Date of last physical exam _____ Date of last dental visit _____

Referring Facility _____ Referring Facility Phone_____

Is the patient currently pregnant? ___Yes ___No Date of first menses? _____

Does the patient have any allergies? ___No ___Yes (Please describe) _____

Are the patient immunizations up to date? ___Yes ___No

Any accidents? ___Yes ___No (please describe) _____

List past seizures, head injuries, loss of consciousness _____

Medication History

Medication Name/Dosage	Start/Stop Date	Effectiveness/Side Effects	Comments

Mental Health Treatment History

Description	Date	Hospital/Program	Therapist/Counselor	Comment

Please indicate by a check if the patient or family members (including parents, brothers, sisters, grandparents or your immediate family) have had any of the following conditions:

Condition	Patient	Family	Condition	Patient	Family
Diabetes			Musculoskeletal problems		
Skin Problems			Edema		
Allergies			Thyroid problems		
Eye trouble, poor vision			Obesity		
Ear, nose, throat problems			Hepatitis/liver disease		
Severe tooth/gum problems			Gallbladder disease		
Tuberculosis/+ skin test			Substance abuse (alcohol, drugs)		
Frequent colds			Frequent indigestion (heartburn)		
Shortness of breath			Frequent nausea/vomiting		
Asthma			Diarrhea/constipation		
Pneumonia			Rectal problems		
Cigarette smoking/marijuana			Recent gain/loss of weight		
High blood pressure			Kidney disease		

Rheumatic fever/arthritis			Urinary tract (bladder) infection		
Blood clots			Venereal disease (VD)		
Stroke/heart problems			Severe headaches		
Anemia			Convulsions		
Sickle cell			Dizzy spells/fainting		
High cholesterol			Severe depression/anxiety		
Mononucleosis			Birth defects		
Bleeding problems			Tumor/cancer		
Inherited diseases: Please list			Other mental health issues: Please list		

Family

Family of origin Please describe the patient's relationships

Father	Supportive_____	Conflicted_____	Estranged_____
Mother	Supportive_____	Conflicted_____	Estranged_____
Step-Father	Supportive_____	Conflicted_____	Estranged_____
Step-Mother	Supportive_____	Conflicted_____	Estranged_____
Siblings	Supportive_____	Conflicted_____	Estranged_____
Step-Siblings	Supportive_____	Conflicted_____	Estranged_____
Other:	Supportive_____	Conflicted_____	Estranged_____

Patient's areas of stress? (relationships, health, school, family, legal, other)

_____

_____

Does patient have problems with cell phone, video viewing, gaming or social media? ____Yes ____ No

Describe methods of discipline typically used in the home_____

Do caregivers agree on how the patient is disciplined? ___yes ___ no ___(Explain)_____

Patient's Pregnancy and Birth Information

Prenatal History	Yes	No	Labor History	Yes	No
Child planned pregnancy?			Delivery spontaneous?		
Mother took medication during pregnancy?			Delivery induced?		
Mother drank alcohol during pregnancy?			Forceps used?		

Mother smoked during pregnancy?			Nuchal cord?		
Mother used illicit drugs during pregnancy?			Meconium staining?		
Any complications during pregnancy?			Problems with delivery?		
Baby full term at delivery?			Problems shortly after birth?		

Comments _____

Birth weight _____ Any problems with the pregnancy or delivery? ____No ____Yes (describe)_____

_____ Weeks old at delivery? _____

Infancy: Birth to two years significant delays

___None ____Yes (explain)_____

Infant Behaviors Information

Infant Behaviors	Yes	No
Unable to develop regular sleeping pattern		
Very difficult to soothe when upset		
Unable to calm self when distressed		
Unable to separate from parent without distress		
Unable to show affection		

Todder to School Age Development

Toddler/Preschool: **Significant Delays** (walking, talking, toilet control, tied shoelace, wrote name, etc.)

___None ____Yes (explain) _____

School age: **8-12 Years Significant Delays** (attention problems, puberty issues, lack of attendance, etc.)

___None ____Yes (explain) _____

Middle School/High School: 13-18 Years Significant Delays

___None ____Yes (explain) _____

Eating and Sleeping Patterns

How would you describe patient's appetite? (good, fair, improving, poor, other) _____

Eating Behavior Concerns

Frequency and degree of restrictive eating (explain) _____

Age of first diet _____

Frequency and severity of binge eating (explain) _____

Frequency and severity of purging (explain) _____

Tool(s) used for purging? (exercise, laxatives, diuretics, diet pills, other) _____

_____

Additional Eating and Nutritional Concerns

Nutrition Concerns ___ Constipation ___Diarrhea ___Moth sores/unable to swallow ___ Nausea/Vomiting ___

Constipation ___Eating disorder ___Enteral feedings ___Fluid intake less than 50% of normal in last 3 days

Impaired nutritional intake ___Lactation ___Skin breakdown or pressure ulcer___ TPN___

Additional Weight and Body Image Concerns

Height _____ Current weight _____ Lowest weight/date _____ Highest weight/date _____ Goal weight _____

Goal pant size _____ Frequency of weighing _____ Comments on weight/body: (body image, body checking, app usage, family/peers influence) _____

Does the patient have any disordered sleep? ___ No ___ Yes (Please explain)

_____

Sexuality

Menarche Onset Age _____ Sexual orientation ___ Heterosexual ___ Homosexual ___ Other _____

Gender identity _____

Is the patient sexually active ___Yes ___No Age of First Sexual Contact: ___ N/A _____Age

Patient's type of contraception/protection_____

Does the patient have any problematic sexual behaviors? _____

Current Living Situation of the Patient

Family Member/Significant Relationship/Other	Age	Relationship to the Patient	Living with the Patient	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Please describe the patient's type of living situation (single family home, apartment/condo, homeless, shelter, assisted living, extended care facility, foster home, group home, juvenile facility, multiple homes, other)

_____

Parent Occupations _____

Where was the patient born and where have they lived? _____

If patient does not live with parents, reason why _____

Is the patient adopted? ___Yes ___No Age of adoption? _____ **Is the patient a foster child?** ___Yes ___No

If patient is a foster child, list caseworker's information: Name_____

Phone number _____ County _____

Major illness in household? ___No ___ Yes (explain) _____

Alcohol abuse in household ___ yes ___no **Substance abuse in household** ___yes ___no

Abuse or neglect in household ___no ___yes _____

Patient feels unsafe in home ___ yes ___ no **Patient has safe place to go** ___yes ___no

Other risks in the home environment ___no ___yes _____

Agency(s)/Others notified ___ no ___yes Agencies: _____

Education

Education Details	Yes	No
Attends School Regularly		
Grade Repeated		
Suspensions, Expulsions		
Special Education Services (IEP)		
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Counseling		

Average Grades _____ Year in School _____

School Name _____

Comments on Education _____

Current legal status ___none ___incarcerated ___parole ___probation ___pretrial release ___other: _____

number of previous incarcerations: _____ supervising officer/case manager name and contact information _____

_____

Cultural & Spiritual

Please describe the patient's religious affiliations, involvement in faith community and guiding spiritual practices

___None _____

Please describe any cultural issues/practices you would like us to be aware of that would affect the patient's treatment

___None_____

Leisure activities Please describe the patient's hobbies, interests, social life and volunteer work

_____

Coping Strengths What strengths does the patient have?

_____

Coping Difficulties What difficulties does the patient have?

_____

Manager of financial affairs ___Self ___Other (Please describe) _____

Does the patient have an advanced directive? ___Yes ____No

Emergency Contact Information

Name_____Relationship_____

Address_____

Shared address with the patient?___Yes ___No Phone number_____

Name_____Relationship_____

Address_____

Shared address with the youth?___Yes ___No Phone number_____

Manager of financial affairs ___Self Other (Please describe) _____

Signature_____**Date**: _____**Time:** ____