Client's Name_____

BIOPSYCHOSOCIAL HISTORY & ASSESSMENT
(For our clients who are 18-years-old and older)

*Please complete to the best of your ability the information below that asks questions about you or the person you are seeking services for.

SECTION 1: GENERAL INFORMATION:

Name of person who is completing this form: _____ Relationship to client: _____

Client's Name:_____ Today's Date:_____

Address:_____
City:_____ State:_____ Zip Code:_____
How long has the client lived at this address:_____ Phone Number: _____
Email Address: _____
Client's D.O.B.:_____ Gender: Male / Female / Transgender / Non-Binary / Other: _____
Preferred Pronoun: He / She / They / Other: _____
Client's SS#:_____

Who should be contacted if there is an emergency?

Emergency Contact's Name_____

Address_____

Phone Number_____

Relationship to Client_____

Who referred client for services?: □ Family member □ Friend □ Doctor □ Insurance Agency □ Phone Book □ Internet
□ Other _____

Presenting Problem/Recent Stressor(s) - What are the main reasons that you are seeking services for yourself/client at this time?

_____
_____
_____

Briefly describe how you hope that services through this agency may help you/client:

_____
_____

Treatment Assignment Info (preferences are not guaranteed, but are helpful for our staff):

Do you have a preference as far as the therapist's gender? □ Male □ Female □ Does not matter

Are there any other preferences regarding therapist/therapy?

_____

What day/days or time of the day work best for you regarding scheduling future appointments? (Weekends/Evenings are not guaranteed)

_____

Are there any issues that may affect your ability to regularly attend your appointments? (Transportation, work/school schedule, physical health, child care, financial issues, etc.)?

_____

Client's Name_____

SECTION 2: CHIEF COMPLAINTS: Place a checkmark next to all symptoms below that help explain the problems that you/client are experiencing at the present time.

- ☐ Abuse (Physical/Sexual/Emotional)
- ☐ Aggressive or violent behavior
- ☐ Anger issues
- ☐ Bladder or bowel control problems
- ☐ Complaints about school behavior
- ☐ Criminal behavior/Involved with probation or parole
- ☐ Cruelty/Harm to animals
- ☐ Depression, Sadness or feeling down
- ☐ Developmental Delays (Delays in learning, growth, speech, social)
- ☐ Drug Use/Alcohol Use
- ☐ Easily Distracted
- ☐ Eating problems (Not eating enough/Overeating)
- ☐ Fatigue/Feeling tired/Lack of energy
- ☐ Fear of "going crazy"
- ☐ Fear of losing control
- ☐ Feeling disconnected from your body
- ☐ Flashbacks
- ☐ Gambling
- ☐ Hopelessness
- ☐ Housebound (Does not want to leave the house)
- ☐ Hyperactivity (Full of energy all day long)
- ☐ Identity issues (Confusion about who you are or want to be)
- ☐ Impulsive behavior (Does not think before acting)
- ☐ Irritability (Often acts miserable and complains a lot)
- ☐ Loss of a loved one, Loss of a relationship, Grief Issues
- ☐ Lying
- ☐ Mood swings
- ☐ Nervousness (Worrying/Anxiety)
- ☐ Nightmares
- ☐ Numerous physical complaints (Complains about feeling sick)
- ☐ Obsessive thoughts (Cannot stop thinking about something no matter how much you try not to)
- ☐ Panic Attacks
- ☐ Paranoia (Extreme fear or distrust of others)
- ☐ Poor grades
- ☐ Poor hygiene/Self-care (Problems with bathing and keeping body clean)
- ☐ Problems concentrating
- ☐ Problems getting along with others/making and keeping friends
- ☐ Problems remembering things
- ☐ Racing thoughts
- ☐ Recent trauma (Please specify): _____
- ☐ Relationship (Marriage/Significant other) or family conflict
- ☐ Seeing or hearing things that other people cannot see/hear
- ☐ Self-harm such as cutting/burning self
- ☐ Setting fires
- ☐ Severe or chronic pain
- ☐ Sexual Issues
- ☐ Sleep problems (Increased or decreased need to sleep)
- ☐ Stealing
- ☐ Tobacco use
- ☐ Other_____

Client's Name_____

SECTION 3: PSYCHIATRIC/MENTAL HEALTH ASSESSMENT:

1. Are you (or the client) currently receiving mental health treatment with this agency or through another agency? If yes, please explain what other services you are currently receiving.

   _____

   _____

2. Have you (or the client) ever had counseling services before? If yes, please list where and when.

   _____

   _____

3. Have you (or the client) ever been hospitalized for mental health problems before? If yes, please list where and when.

   _____

   _____

4. Have you (or the client) ever been diagnosed with a mental health condition? If yes, please list the diagnosis/diagnoses and who made the diagnosis/diagnoses.

   _____

   _____

5. Have you (or the client) ever spent time in a residential treatment facility or another long term treatment facility? If yes, please list where and the dates that you were in treatment.

   _____

   _____

6. Have you (or the client) ever had thoughts that you wanted to harm or kill yourself? If yes, are these thoughts that you have had recently? If yes to either question, please explain:

   _____

   _____

7. Have you (or the client) ever had thoughts that you wanted to harm or threaten someone else? If yes, are these thoughts that you have had recently? If yes to either question, please explain:

   _____

   _____

8. Have you (or the client) ever cut, burned or injured yourself in a way that was not an accident? If yes, please explain and note if is this a current concern:

   _____

   _____

9. Do you have a WRAP plan or Advanced Directive regarding your mental health?

   _____

   _____

Client's Name_____

SECTION 4: BRIEF FAMILY HISTORY:

1. Do you (or the client) have any family members who suffer from mental health problems? If yes, please explain:

2. Do you (or the client) have any family members who suffer from drug and/or alcohol problems? If yes, please explain:

3. Are there any family members close to you (or the client) that are suffering from any medical conditions that may be upsetting for you? If yes, please provide more information.

4. Do you (or the client) have any family members who are or have been incarcerated? If yes, please explain:

5. Do you (or the client) have any family members who have committed suicide? If yes, please explain:

6. Are there any concerns regarding family members (either living or deceased) that may be impacting you (or the client) at the present time? If yes, please explain.

SECTION 5: MEDICAL SCREENING: PERSONAL AND FAMILY MEDICAL HISTORY:

1. Have you (or the client) been diagnosed with any medical conditions? If yes, please list all current medical conditions.

2. Do you (or the client) have additional medical issues/symptoms that you are concerned about? Have you seen a doctor for any of these complaints?

3. On average, how many hours of sleep do you (or the client) get per day/night?

4. Overall, do you think that you (or the client) have healthy eating habits? If no, please explain.

5. Do you (or the client) have a family doctor/primary care physician? If yes, please list doctor's name, agency they are affiliated with, and doctor's address and phone number if known.

6. Have you (or the client) had a physical exam in the last year? If yes, please include the date of last exam and the outcome.

7. To the best of your knowledge, what is your current weight and height? Do you or your doctor have any concerns about your current weight?

8. Do you (or the client) take any medication(s)? If yes, please list the current medication name(s), dosage, how often you take the medication, who is prescribing the medication, and what you are taking the medication for.

9. Do you (or the client) have any allergies that you know of? If yes, please list.

10. Have you (or the client) ever had surgery or been hospitalized for any medical problems? If yes, please explain.

SECTION 6: ADDICTION HISTORY:

1. When was the last date you (or the client) drank alcohol? What did you drink and how much did you drink?

2. What do you usually drink, how much do you drink and how frequently are you/were you (or the client) drinking alcohol?

3. How old were you (or the client) when you first started drinking alcohol?

4. Have you (or the client) ever used drugs? If yes, list what specific drugs and how much do you use?

5. When was the last date you (or the client) used drugs? What did you use and how much did you use?

6. How frequently are you/were you (or the client) using drugs?

7. How old were you (or the client) when you first started using drugs?

8. Do you (or the client) gamble regularly (lottery tickets, sporting events, internet, etc.)? If yes, how frequently?

9. How old were you (or the client) when you first started gambling?

10. Do you (or the client) spend money in excess? If yes, how frequently?

11. If you (or the client) spend money in excess, what do you tend to spend your money on?

12. Has your (or the client's) spending ever impacted your ability to pay your bills on time? If yes, please explain.

13. Do you (or the client) view pornographic materials? If yes, how frequently?

14. Do you (or the client) often continue to eat after you feel full? If yes, please explain.

15. Do you (or the client) ever feel guilty after eating? If yes, please explain.

16. Do you (or the client) ever deprive yourself of food? If yes, please explain.

17. Do you (or the client) spend excessive time with media devices such as phone/computer/gaming? If yes, please explain.

_____

_____

18. Is there any other behavior that you believe you do in excess or are concerned about? If yes, please explain.

_____

_____

ADDICTION TREATMENT:

1. Have you ever been concerned at any time about any of the above behaviors listed in questions 1-18? If yes, please explain.

_____

_____

2. Is anyone concerned about you (or the client) regarding the above behaviors listed in questions 1-18? If yes, please explain.

_____

_____

3. Have any of the above behaviors listed in questions 1-18 impacted your (or the client's) relationships with family and friends? If yes, please explain:

_____

_____

4. Have any of the above behaviors listed in questions 1-18 impacted your (or the client's) ability to perform your responsibilities at work, home and/or school? If yes, please explain.

_____

_____

5. Have you (or the client) ever received treatment for any of the above behaviors listed in questions 1-18? If yes, where and when?

_____

_____

6. Would you (or the client) like to receive help for any of the above behaviors listed in questions 1-18?

_____

_____

SECTION 7: TRAUMA HISTORY:

1. Have you (or the client) ever been physically, sexually, emotionally, verbally abused or neglected as a child? If yes, please explain.

_____

_____

2. Have you (or the client) ever physically, sexually, emotionally, verbally abused or neglected a child(ren)? If yes, please explain.

_____

_____

3. Have you (or the client) ever been charged with physically, sexually, emotionally, verbally abusing, neglecting or assaulting others? If yes, please explain.

4. Are you now or have you (or the client) ever been in a relationship where you were physically, sexually, emotionally or verbally abused? If yes, please explain.

5. Have you (or the client) ever witnessed physical, sexual, emotional or verbal abuse? If yes, please explain.

6. Have you (or the client) ever witnessed or experienced domestic violence or any other type of violence? If yes, please explain.

7. Have you (or the client) ever witnessed or experienced any other type of traumatic event? If yes, please explain.

8. Have you (or the client) ever placed a PFA (Protection From Abuse) on anyone? If yes, please explain.

9. Have you (or the client) ever been served with a PFA? If yes, please explain.

10. Have you (or the client) ever experienced discrimination on the basis of your race, religion, age, gender, sexual orientation, disability, etc.? If yes, please explain.

SECTION 8: LEGAL ASSESSMENT:

1. Have you (or the client) ever been charged with a summary offense, misdemeanor, felony, etc.? If yes, please explain.

2. Do you (or the client) have any pending charges? If yes, please explain.

3. Are you (or the client) currently on probation/parole? If yes, please explain.

Client's Name_____

SECTION 9: FAMILY ASSESSMENT:

1. Where (City/State) were you (or the client) born and raised?

2. Who raised you (or the client)? (Biological parents/Grandparents/Foster Care, etc.)

3. Do you (or the client) have any brothers/sisters? If yes, please list names and ages.

4. Do you (or the client) have any children? If yes, please list names, ages and where they reside.

5. Are there any services/agencies involved with anyone living in your home (Children and Youth Services, Family-Based Treatment, Behavioral Health Rehabilitation Services, etc.)? If yes, please explain:

6. Please describe how you (or the client) were disciplined as a child.

7. How would you describe your (or the client's) childhood?

8. How would you describe your (or the client's) current relationship with your family?

9. What is your (or the client's) current relationship status? (Married/Single/Divorced/Separated/Widowed)

SECTION 10: DEVELOPMENT:

1. Were you (or the client) born healthy and without any complications? If no, please explain.

2. Did you (or the client) walk, talk, toilet train, etc. at the correct developmental times? If no, please explain.

3. Did you (or the client) receive speech therapy, occupational therapy, physical therapy, etc? If yes, please explain.

4. Did you (or the client) have any exposure to drugs, alcohol or tobacco use by your mother during her pregnancy?

5. Was there any domestic violence between your mother (or the client's) and any other parties when your mother was pregnant with you? If yes, please explain.

SECTION 11: LIVING SITUATION:

1. Who do you (or the client) live with currently? Please list ALL household members, their relationship to you (or the client) and how well you get along.

2. Have you (or the client) had multiple changes in living situations throughout your life? If yes, please explain.

3. Have you (or the client) ever lived with someone who was suffering from a mental illness? If yes, please explain.

4. Have you (or the client) ever lived with someone who has a drug/alcohol problem? If yes, please explain.

5. Have you (or the client) ever been homeless? If yes, please explain.

SECTION 12: PERSONAL ASSESSMENT:

Leisure Activity:

1. How do you (or the client) spend your free time?

2. What hobbies/interests do you (or the client) have? What activities do you like to do?

3. What are you (or the client) good at? What do other people tell you that you are good at?

_____

_____

4. What do you think your (or the client's) strengths are? What do other people tell you that your strengths are?

_____

_____

5. What do you think your (or the client's) weaknesses are?

_____

_____

Cultural Identity Aspects: (Please complete if you feel comfortable)

1. What is your family nationality/ethnic background?_____

Primary language spoken: □ English □ Spanish □ Other_____

2. If primary language spoken is not English, do you speak/understand English? _____

3. Are there any cultural or special practices that may impact your attendance/participation in treatment?

_____

_____

4. Is there anything about your (or the client's) culture that you would like us to know to best help you?

_____

_____

Sexuality and Gender: (Please complete if you feel comfortable)

1. What is your (or the client's) identified gender? (Male / Female / Transgender / Non-Binary / Other)

_____

_____

2. How do you (or the client) identify your sexual orientation?

_____

_____

3. Are you (or the client) experiencing any conflict over your identified gender or sexual orientation? If yes, please explain:

_____

_____

Spirituality Assessment: (Please complete if you feel comfortable)

1. Do you (or the client) have a spiritual/religious preference? If yes, please explain:

_____

_____

2. Are you (or the client) actively involved within your spiritual/religious community? If yes, please explain:

3. Who or what about your spiritual/religious preferences provides you (or the client) with strength and hope?

4. What type of spiritual/religious support would you (or the client) like, if any, while here?

5. Have your spiritual beliefs helped you (or the client) with your problems? If yes, please explain:

SECTION 13: VOCATIONAL/EDUCATIONAL HISTORY:

1. What is the highest level of schooling you (or the client) have completed?
2. Did you (or the client) have any learning or behavior problems at school? If yes, please explain.
3. Describe your (or the client's) ability to make and keep friends in school.
4. Were you (or the client) involved in extracurricular activities while in school such as sports/clubs, etc.? If yes, please describe.
5. Are you (or the client) currently working? If yes, please explain what you do and if you are working part-time or full-time.
6. If you (or the client) are working, or have worked in the past, are you experiencing any work-related problems in the past/present?
7. If you (or the client) are unemployed, what is your primary source of income?

Client's Name_____

SECTION 14: MILITARY HISTORY:

1. Have you (or anyone in your immediate family) ever served in the military? If yes, what branch and for how long? What is the status of your discharge?

   _____

   _____

2. Were you involved in any combat situations while serving in the military? If yes, please explain.

   _____

   _____

3. Did you ever observe/experience a serious injury or death of another individual while serving in the military? If yes, please explain.

   _____

   _____

4. Have you ever been diagnosed with Combat PTSD? If yes, please explain.

   _____

   _____

5. Did you have any other notable military difficulties? If yes, please explain.

   _____

   _____

SECTION 15: OTHER:

Please use the following space to list anything concerning you (or the client) that may not have been asked that you would like to be addressed.

_____

_____

_____

_____

_____

I verify all information is truthful to the best of my knowledge (please sign below):

_____

Client Signature Date

STAFF USE ONLY

I verify I reviewed the above information:

_____

Staff Signature Date

Printed Name of Clinician Reviewing this form_____

_____

Staff Signature Date

Printed Name of Clinician Reviewing this form_____