ADULT (Age 18 and over)
BIOPSYCHOSOCIAL ASSESSMENT

Please answer all questions. Please do not write in boxes labeled *therapist use only*. Thank you!

Name	Preferred Name	Birthdate
If this form was completed by someone else, their name/relationship to you		Today's Date

Your treatment goals are of highest importance to us. Please complete the following questions; your therapist will discuss these with you at your first visit.

Why are you coming to treatment now?

What would you like to be different after treatment here?

Strengths & Abilities Your assets, natural positives (examples: good support system, I'm motivated, coping skills, etc) and your skills, capabilities, competencies and talents (e.g., capacity to learn, common sense, academic intelligence, social skills, creativity, etc)

Needs Specific things that will make treatment here successful (e.g., figuring out consistent transportation, prioritizing therapy, accessibility of services re: disability, need for assistive technology, support of family, etc)

Preferences Things that will *enhance* your treatment experience (e.g., trying therapy with or without psychiatric medications, type of therapy, type of therapist, appointment times/days, etc).

Barriers What might get in the way of achieving your goals?

What have you already done or tried to do to address the goals that bring you here?

PSYCHOLOGICAL SYMPTOMS AND HISTORY

Please check any of the following that are currently bothering you:

- □ Worrying too much
- □ Feeling tense
- □ Feeling fearful
- □ Panic attacks
- □ Startle easily
- □ Trauma/abuse
- □ Being scared for no reason
- □ Worrying what others think about me
- □ Having to redo things or check things
- □ Doing things very slowly to make sure they are correct
- □ Unwanted thoughts
- □ Avoiding things I am afraid of
- □ Asking others for reassurance
- □ Couples problems
- □ Family problems
- □ Problems with children
- □ Difficulty making friends
- □ Withdrawing
- □ Loneliness
- □ Work/school problems
- □ Financial problems
- □ Sexual problems
- □ Infertility
- □ Trouble concentrating
- □ Easily distracted
- □ Memory problems
- □ Racing thoughts
- □ Procrastination
- □ Careless mistakes
- □ Start but don't finish tasks
- □ Irritability/easily annoyed
- □ Sadness
- □ Crying easily
- □ Hopelessness
- □ Worthlessness
- □ Low self-confidence
- □ Feeling inferior
- □ Low energy level
- □ Difficulty making decisions
- □ Feeling confused
- □ Loss of interest/pleasure
- □ Thoughts of suicide
- □ Increased sleep
- □ Decreased sleep
- □ Problems falling asleep
- □ Problems staying asleep
- □ Fatigue/feeling tired
- □ Nightmares
- □ Appetite change
- □ Self injury
- □ Excessive spending
- □ Impulsivity
- □ Hyperactivity
- □ Seeing/hearing things that other people don't see/hear
- □ Feeling something is wrong with your mind
- □ Feeling disoriented
- □ Feeling high without being on drugs
- □ Mood swings
- □ Feeling numb
- □ My feelings being easily hurt
- □ Difficulty controlling thoughts
- □ Difficulty controlling actions
- □ Being suspicious of others
- □ Someone's death
- □ My weight
- □ My eating
- □ Purging
- □ Food restriction
- □ Hair-pulling
- □ Skin-picking
- □ Gambling
- □ Sexual addiction
- □ Internet addiction
- □ Upset Stomach
- □ Headaches
- □ Chronic Pain
- □ Anger
- □ Being violent
- □ Homicidal thoughts
- □ Other:

Please note: *Substance use concerns are explored in detail at the end of this packet*

PREVIOUS COUSELING/PSYCHOTHERAPY

Have you been seen previously for treatment or evaluation of psychological or psychiatric concerns? □ Yes □ No

Check if applicable: □ Inpatient □ Residential □ Day Treatment/Partial Hospitalization □ Substance Abuse Program □ Outpatient □ Psychological Testing □ Psychiatric Evaluation □ _____

Name of Facility and/or Provider	Date(s)	Problem Area/Diagnosis & Type of Therapy	Was it helpful?

Have you had (now or in the past): □suicidal feelings or thoughts □suicide plan □suicide attempt(s) □self-harm behavior (cutting, etc) □explosive anger □homicidal feelings, thoughts or plan □_____ □no history of suicidal/homicidal thoughts, plans or actions, now or in the past **Comments**

Abuse/Trauma Have you been (now or in the past) the □victim of, □witness to, or □perpetrator of:

□ physical abuse or assault □ a life-threatening event □ sexually abuse or assault □ emotional or verbal abuse □ neglect □ no history of abuse/trauma/neglect **Comments**

Do you currently have concerns about your personal safety? □Yes □No If Yes, please describe

Client Name _____

HEALTH INFORMATION

Physician:
Date of Last Physical/Annual Exam:
How is your health in general? □ Excellent □ Good □ Fair □ Poor □ Other:_____

Current on immunizations? □ Y □ N
Are you pregnant? □ Y □ N If yes, # weeks:_____
Have you had miscarriage(s)? □ Y □ N

Check any of the following that you have had or currently have:

□ Major accident/injury
□ Hospitalization
□ Surgery
□ Adverse medication reaction
□ Allergies
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Birth defects
□ Bladder problems
□ Blood pressure (high/low)
□ GI problems
□ Cancer
□ Cerebral Palsy
□ Chronic fatigue
□ Dental problems
□ Diabetes
□ Epilepsy
□ Fibromyalgia
□ Head trauma (loss of consciousness? □Y □N)
□ Headaches
□ Hearing problem
□ Heart disease
□ Hepatitis A B or C
□ Hypoglycemia
□ Huntington's
□ Kidney problems
□ Learning Disability
□ Liver problems
□ Lung condition
□ Menopause
□ Multiple Sclerosis
□ Parkinson's Disease
□ Speech/language problem
□ Stroke
□ Thyroid (Hypo/Hyper)
□ Ulcer
□ Vision problem
□ Other (please list):

Please provide additional detail about items checked above:

Do you have any disabilities not noted thus far? □ Y □ N ***If Yes, please describe:***

Please list all current prescribed &/or over-the-counter medications/supplements. (If none, check this box ☐)

Medication	Dosage	Prescribed by	Medication	Dosage	Prescribed by

If you listed psychiatric medications above, do they seem to be helping? □ No □ A little □ Moderately □ A lot

Please list any psychiatric medications you recall using in the past:

Client Name _____

FAMILY INFORMATION

Marital Status ☐ Single ☐ Partnered/Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Please list people currently living with you

Name	Relationship to you	Age	Satisfied with relationship? (Y/N)	Comments

Please list children not living with you. (If you have any deceased children, please write "deceased" and age at time of death.)

Name	Age	Lives with	Satisfied with relationship? (Y/N)	Comments

Please list members of your family of origin (parents, siblings, step-family, etc) that are not listed above.

Name	Relationship to you	Age (if deceased, write "deceased" and age at death)	Satisfied with relationship? (Y/N)	Comments

Family Mental Health Have any of your immediate family members had mental health problems (anxiety, depression, substance use, suicide, etc)? ☐ Yes ☐ No If yes, please describe

Your place of birth:

Were you adopted? ☐ Yes ☐ No

Ethnic identification ☐ African American ☐ Caucasian ☐ Native American ☐ Hispanic ☐ Latino ☐ Asian ☐ Not Listed (please specify):

Sexual Identification ☐Straight ☐Gay/Lesbian ☐Bisexual ☐Not Listed

Gender Identity & Expression _____

Friendships ☐ No friends ☐ Only acquaintances ☐ Acquaintances & friends

Are you satisfied with your friendships? ☐ Yes ☐ No

Do you have sufficient social support? ☐ Yes ☐ No

Comments:

Previous Relationships Please list previous significant relationships (e.g., dissolved marriages, partnerships, etc).

If not applicable, check this box ☐

Client Name _____

EDUCATIONAL & VOCATIONAL INFORMATION

Schools/colleges attended

School/College Name	Diploma/Degree	Area of Study

Comments:

Literacy Level □ Not able to read □ Recognize 1 or 2 words when reading □ Read some/most simple writing □ No concerns

Employment History

Job	Organization	Length of Time	Satisfied with Job?	Reason for Leaving

Comments:

Military Service

□Yes □ No If yes, please specify rank _____ branch _____ saw combat?_____

Discharge year:_____ Honorable discharge? □Yes □No

RELIGION/SPIRITUALITY

□Protestant □Catholic □Jewish □Buddhist □Hindu □Muslim □Agnostic □Atheist □Other

Presently active in religion/spirituality? □Yes □No □N/A Satisfied with religion/spirituality? □Yes □No □N/A

Comments:

LEGAL INFORMATION

Have you (currently and/or or in past): If any legal difficulties, please describe:

□Had difficulty or contact with police?

□Been convicted of a crime?

□Been on Probation?

□No history of legal problems

LEISURE ACTIVITIES

Please list your leisure activities (hobbies, activities used for stress relief, tasks you enjoy in your spare time):

Are you satisfied with these activities (e.g., frequency, enjoyment, etc)? □Yes □No Comments:

Client Name _____

SUBSTANCE USE: Please complete the chart below and circle any of the substances listed if you have used them in the past 48 hours.

			Please complete these questions for substances you currently use						
Category of Substance	Current Use?	Ever used?	Amount and Frequency of Use (e.g., 8 beers/day)	How often do you have a strong urge to use? (hourly, daily, every other day, etc)	Use has led to problems (social, health, legal, work)	Don't do what's expected of me due to use	Others express concern about my use	Have tried to cut down or stop	With-drawal symptoms
Alcohol	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Stimulant	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Cocaine	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Tranquilizer	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Barbiturate	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Marijuana	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Opioid	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Hallucinogen	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Prescribed	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Nicotine	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Caffeine	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y
Other	☐N ☐ Y	☐N ☐ Y			☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y	☐N ☐ Y

Specify Drug / Alcohol of Preference:_____

Do you use Drugs / Alcohol in combination? ☐ No ☐ Yes If yes, describe:_____

Ever treated for alcohol or drug poisoning? ☐ No ☐ Yes Number of blackouts:_____

Twelve Step (e.g., Alcoholics Anonymous) or other addiction group attended? ☐ No ☐ Yes

**********THIS IS THE END OF THE CLIENT PORTION OF THIS FORM**********

For Therapist Use Only

☐ Family history of abuse/dependence

Substance Abuse ☐ Role impairment ☐Hazardous use ☐Legal problems ☐Social/Interpersonal problems

Substance Dependence (3+, 12 mo) ☐ Tolerance ☐ Withdrawal symptoms ☐ Larger amounts/longer period than intended ☐ Social/work/recreational activities reduced ☐Use despite physical/psychological consequences ☐Excessive time obtaining/using/recovering ☐Desire to cut down/Unsuccessful control attempts
☐ Physiological dependence
☐ Remission (early full, early partial, sustained full, sustained partial)

☐ No SA concerns ☐ Consult with Site Manager ☐ Further screening needed ☐Referral Indicated
Comments (*if consult/eval needed, document date completed and consultant's name below and detail relevant information in a progress note*)

Client Name _____

MEDICAL HISTORY (Include adjustment to disabilities and/or medical conditions or □ N/A *as well as* relationship of physical health to current mental health or □ N/A)

NUTRITION HISTORY □no concerns □calorie restriction □diet □food group avoidance □emotional overeating □binge eating □purging □ruminative thoughts about food/weight □body image concerns □history of food concerns (specify:

Assessment □Eating inventory assigned □Consult w/ Site Manager □Referral to specialist needed □No problem indicated

FAMILY/SOCIAL HISTORY AND FUNCTIONING *Please include brief history/functioning as well as discussion of potential impact & integration of applicable items into treatment*

Family of origin

Present family situation

Strengths/resources in family/friends; need for social supports

Spirituality

Cultural background/family values/ethnicity (□ **No concerns relate to ethnicity when asked)**

Gender identity/sexual orientation/gender expression

Overall Assessment of Family/Social Impairment □None □Mild □Mild to Moderate □Moderate □Moderate to Severe □Severe
Comments

ACADEMIC/VOCATIONAL/LEISURE FUNCTIONING
Assessment of impairment □None □Mild □Mild to Moderate □Moderate □Moderate to Severe □Severe **Comments**

Activities that may be beneficially integrated into treatment

LEGAL STATUS (□ no legal concerns or history)

□ **Client given information about legal assistance if relevant**

Client Name _____

INITIAL RISK ASSESSMENT

Client reports current □ Ideation □ Intent □Means □Plan □None of These **Comments** *including potential protective & risk factors*

Client reports past □ Ideation □Intent □Means □Plan □ Attempts □None of These **Comments**

Client reports other past or current risk-taking behaviors □ No □ Yes, comments:

Intervention Needed □ None □ Complete Full Risk Assessment □ Safety Plan □ No Harm Contract □ Consult with Site Manager □ Referral to Higher Level of Care

MENTAL STATUS

General Behavior □ Cooperative □Passive □Withdrawn □Dramatic □Restless □Hostile □Guarded

Appearance □Tidy □Unkempt □Disheveled □Other **Orientation X 4** □Adequate □Deficiency→ □Time □Place □Person □Situation

Motor Activity □Normal Limits □Agitated □Psychomotor Retardation □Tremor □Tic □Mannerism □Stereotypy □Difficulty sitting still □Lack of Eye Contact

Affect Intensity □Full range □Constricted Range □Flat □ Blunted □Exaggerated □ Dramatic □Other

Affect Mobility □ Unremarkable □Constricted □Fixed □Immobile □Labile □Reactive □Unreactive

Mood □Euthymic □Euphoric □Depressed □Tearful □Sad □ Anxious □Angry □Composed □Labile □Alexythymic

Speech □Normal Limits □Loud □Soft □Non-spontaneous □Slowed □ Hesitant □ Rapid □Pressured g □Excessive □Incoherent □Articulation Problems □Prolonged Latency □ Repetition of Words □ Other

Thought Process □Normal Limits □Flight of Ideas □Inhibited □Poverty of Thought □Perseveration □Disorganized □Ruminative □Circumstantial

Thought Content □Normal Limits □Illogical □Delusional □Overvalued Ideas □Paranoid □Obsessions □Preoccupations

Perception □Normal Limits □Hallucinations □Pseudohallucinations (e.g., hypochondriasis) □Illusions

Alertness □Unremarkable □Impaired **Memory** □Normal Limits □Inadequate→ □Immediate □Recent □Remote

Attention/Concentration □Normal Limits □Mild Impairment □Moderate Impairment □Severe Impairment

General Knowledge □ Unremarkable □ Inconsistent with Education □Overly Abstract □Concrete

Insight □Absent □Good □Fair □Minimal □None **Judgment** □Good □Fair □Poor

DIAGNOSTIC SUMMARY (including symptoms and functional impairment supporting DSM-IV diagnosis; include discussion if applicable of co-occurring disabilities, etc)

Client Name _____

DIAGNOSTIC IMPRESSIONS (DSM-IV Code and Diagnosis)

Axis I : _____

Axis I : _____

Axis II : _____

Axis III : _____

Axis IV : _____

Axis V (GAF) _____

_____ _____

Therapist's Signature Date

Client Name _____