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CONFIDENTIAL BIOPSYCHOSOCIAL ASSESSMENT

DEMOGRAPHICS

NAME:_____

ADDRESS:_____

BIRTHDATE: _____ AGE: _____ GENDER: _____

HOME PH#: _____ MAY WE CALL? Y / N

CELL PH#: _____ MAY WE CALL? Y / N

EMAIL: _____ MAY WE EMAIL? Y / N

EMERGENCY CONTACT: _____ PH #: _____

BILLING INFORMATION

PRIMARY INSURANCE

Insurance: _____

SSN: _____-_____-_____

Relationship to Client: _____

ID Number: _____

DOB: _____

SECONDARY INSURANCE

Insurance: _____

SSN: _____-_____-_____

Relationship to Client: _____

ID Number: _____

DOB: _____

USING EMPLOYEE ASSISTANCE PROGRAM? **Y / N** IF YES, WHICH PROVIDER? _____

AUTH #: _____ # OF SESSIONS: _____

PSYCHOLOGICAL/ MENTAL HEALTH HISTORY

PREVIOUS THERAPY: **Y / N**

DETAILS OF THERAPY: _____

PREVIOUS HOSPITALIZATION: **Y / N**

DETAILS OF HOSPITALIZATION(S): _____

CURRENT/PAST PSYCHIATRIST NAME: _____

PSYCHIATRIST PHONE #: _____

CURRENT/PAST PSYCHOTROPIC MEDICATION: _____

PREVIOUS/CURRENT MENTAL HEALTH DIAGNOSIS: _____

FAMILY HISTORY OF MENTAL HEALTH OR SUBSTANCE ABUSE: _____

_____

BIOLOGICAL/PHYSICAL

PRESENT AND/OR PAST MEDICAL CONDITIONS: _____

PAST MEDICAL COMPLICATIONS, SURGURIES, ACCIDENTS? (IF YES EXPLAIN)

_____

HISTORY OF LEARNING DISABILITIES OR DEVELOPMENTAL DELAYS:

_____

PRESENT PRIMARY CARE PHYSICIAN & DATE OF LAST PHYSICAL:

_____

CURRENT MEDICATIONS (include prescription, herbal remedies, vitamins, or over-the-counter):_____

ANY USE OF PRESCRIPTION DRUGS, STREET DRUGS/SUBSTANCES FOR RECREATIONAL USE? **Y / N**

IF YES, PLEASE DESCRIBE USE: _____

IF SO, DO YOU WANT TO CHANGE THE USE OF ANY SUBSTANCES? **Y / N**

FAMILY HISTORY

CURRENT MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐PARTNERED ☐WIDOWED

DESCRIBE YOUR RELATIONSHIP: _____

DO YOU HAVE ANY RELATIONSHIP CHALLENGES? _____

DO YOU HAVECHILDREN? **Y / N** DO YOU HAVE PARENING CHALLEGES: **Y / N**

IF SO, DESCRIBE: _____

WHO DO YOU CURRENTLY LIVE WITH? _____

DESCIBE YOUR CHILDHOOD: _____

DESCRIBE YOUR RELATIONSHIP WITH YOUR FATHER: _____

DESCRIBE YOUR RELATIONSHIP WITH YOUR MOTHER: _____

DESCRIBE YOUR RELATIONSHIP WITH YOUR SIBLING(S): _____

ARE THERE CONCERNS FROM YOUR CHILDHOOD THAT ARE CURRENTLY IMPACTING YOU: **Y / N**

IF YES, PLEASE EXPLAIN: _____

_____

PLEASE CHECK THE FOLLOWING IF EXPERIENCED:

- ☐ EMOTIONAL ABUSE
- ☐ SEXUAL ABUSE
- ☐ PHYSICAL ABUSE
- ☐ PARENT SUBSTANCE ABUSE
- ☐ TEEN PREGNANCY
- ☐ NEGLECT
- ☐ VIOLENCE AT HOME
- ☐ CRIME VICTIM
- ☐ PARENT ILLNESS
- ☐ CHRONIC ILLNESS
- ☐ CAREGIVER
- ☐ FOSTER/ADOPTION
- ☐ MULTIPLE MOVES
- ☐ HOMELESSNESS
- ☐ LOSS OF SOMEONE/JOB
- ☐ FINANCIAL ISSUES
- ☐ BULLYING
- ☐ ABSENT PARENT

EDUCATION

ARE YOU IN SCHOOL PRESENTLY? **Y / N**
DO YOU HAVE SCHOOL RELATED STRESS? **Y / N**
HIGHEST LEVEL OF EDUCATION COMPLETED? _____

EMPLOYMENT

ARE YOU CURRENTLY EMPLOYED? **Y / N** IF SO, WHERE & POSITION:

_____

DO YOU HAVE JOB RELATED STRESS? **Y / N** IF SO, PLEASE DESRIBE:

_____

LEGAL HISTORY

DO YOU HAVE CURRENT OR PAST LEGAL HISTORY: **Y / N**

IF YES, PLEASE EXPLAIN: _____

SOCIAL/CULTURAL/RELIGIOUS BACKGROUND

- I AM APART OF A SPECIFIC CULTURE OR ETHNICITY: **Y / N**
- I ENGAGE IN SPECIFIC RELIGIOUS OR CULTURAL PRACTICES: **Y / N**
- I AM A SPIRITUAL PERSON: **Y / N**
- I AM CONNECTED WITH A RELIGION OR SPIRITUAL GROUP: **Y / N**
- I HAVE SEXUALITY OR GENDER CONSIDERATIONS: **Y / N**

- I HAVE A SUPPORT SYSTEM: **Y / N**

WHAT ARE SOME OF YOUR STRENGTHS, GIFTS AND TALENTS?

_____

WHAT ARE SOME OF YOUR HOBBIES, SPECIAL INTERESTS, ETC?

_____

PRESENTING CONCERNS

PLEASE DESCRIBE THE PROBLEMS THAT BROUGHT YOU IN TODAY:

_____
_____
_____

PLEASE CHECK ALL THE BEHAVIORS AND SYMPTOMS EXPERIENCED IN THE LAST 30 DAYS:

- ☐ DISTRACTIBILITY
- ☐ HYPERACTIVITY
- ☐ IMPULSIVITY
- ☐ MOOD CHANGES
- ☐ SADNESS
- ☐ LOSS OF PLEASURE/INTEREST
- ☐ HOPELESSNESS
- ☐ HELPLESSNESS
- ☐ THOUGHTS OF DYING
- ☐ SELF-HARM
- ☐ CHANGE IN APPETITE
- ☐ LACK OF MOTIVATION
- ☐ WITHDRAWAL/ISOLATION
- ☐ PANIC/ANXIETY ATTACKS
- ☐ CRYING SPELLS
- ☐ LONELINESS
- ☐ GUILT/SHAME
- ☐ FATIGUE
- ☐ FEARFUL
- ☐ ANXIETY/WORRYING
- ☐ OBSESSIVE THOUGHTS
- ☐ COMPULSIVE BEHAVIOR
- ☐ AGGRESSIVENESS
- ☐ IRRITABILITY
- ☐ FREQUENT CONFLICT
- ☐ HOMICIDAL THOUGHTS
- ☐ FLASHBACKS
- ☐ PARANOIA
- ☐ RACING THOUGHTS
- ☐ HEARING VOICES
- ☐ SEEING THINGS
- ☐ SLEEP DIFFICULTY
- ☐ NIGHTMARES
- ☐ EXCESSIVE ENERGY
- ☐ OTHER _____
- ☐ OTHER _____

ARE YOUR PROBLEMS AFFECTING ANY OF THE FOLLOWING AREAS OF YOUR LIFE?

- ☐ EVERYDAY FUNCTIONING
- ☐ WORK/SCHOOL
- ☐ SELF-ESTEEM
- ☐ RELATIONSHIPS
- ☐ LEGAL ACTIVITY
- ☐ HEALTH
- ☐ INTIMACY
- ☐ HYGIENE
- ☐ FINANCES

RISK ASSESSMENT

Y / N IN THE PAST 30 DAYS, HAVE YOU WANTED TO KILL YOURSELF OR KILL SOMEONE ELSE?
Y / N IN THE PAST 30 DAYS, HAVE YOU MADE ATTEMPTS TO KILL YOURSELF OR SOMEONE ELSE?
IF YES TO ANY OF THE ABOVE, DO YOU HAVE A PLAN TO KILL YOURSELF OR KILL SOMEONE ELSE? ***Y / N***
Y / N DO YOU HAVE ACCESS TO FOLLOW THROUGH WITH YOUR PLAN?
Y / N HAVE YOU EVER IN THE PAST 12 MONTHS THOUGHT ABOUT KILLING YOURSELF OR SOMEONE ELSE?
Y / N HAVE YOU EVER IN THE PAST 12 MONTHS ATTEMPTED TO KILL YOURSELF OR SOMEONE ELSE?