CLIENT INTAKE BIOPSYCHOSOCIAL ASSESSMENT FORM

Name:_____ Address:_____

Phone: Home #: _____Work #:_____

Cell #: _____Email:_____

What time and day is best? _____Day time, regular working hours. _____
Okay to leave a phone message? Yes No Text message/Email? Yes No

Age	Date of Birth	Marital Status	Gender	Ethnicity/Race

Occupation: _____Name of Employer /Workplace:_____

Emergency Contact: _____Relationship:_____
Phone: (Home)_____ (Cell)_____

Family Physician Name & Contact Info:_____

Counseling Coverage (If Applicable):

Provider Name Band / Insurance Provider / Other	ID	Contact Information Phone / Address

PSYCHOSOCIAL ASSESSMENT

PRESENTING PROBLEM:

What brought you here today?

_____

_____

_____

Length of time experiencing symptoms (depression, mania, behavioral, psychosis)_

_____

_____

_____

FAMILY HISTORY:

Present Household:

Name Spouse / Child	Age	Relationship Married/Biological/Step	Family Member General Characteristics

Please describe your relationships with the members of your household.

_____

_____

_____

Please describe any family history that impacts you today. (Loss, divorce, tension)

_____

_____

_____

Family History of Mental illness

	Yes	No	Who
Suicide Attempt			
Suicide Completion			
Mental Illness			
Substance Abuse History			

MEDICAL HISTORY

Tell me about any medical problems you have –chronic illnesses, traumatic injuries, head injuries, major surgeries, and/or chronic pain? Includes dates, hospitalization information, disabilities. _____

_____

Current Medication(s):

Prescription Type	Diagnosis	How Often	How Long

Current and/or Prior Mental Health Treatment

Agency, Therapist, or Treatment center	Date of service	Length of service	Reason for treatment	Was treatment successful

Childhood History

Including moves, significant life events losses, etc.

_____

_____

_____

_____

Social Development

Please describe social interactions (friends/family/groups/affiliations). Do you initiate social interactions, appropriate and safe activities, prefer solitary activities, same age peers…, etc.

_____

_____

_____

_____

ADDICTIONS - *Please fill all that apply*

Substance	Age of Onset	Current Use	Last Use	Current or Past treatment	Consequences of Abuse
Alcohol					
Amphetamines					
Benzodiazepines/ Xanax/ Valium					
Cannabis/ Marijuana					
Crack/ Cocaine					
Hallucinogens/Shrooms PCP/LSD/DXM(cough syrup)					
Inhalants					
MDMA/Molly/ Ecstasy					

Opiates/Heroin/ Prescription pain killers					
Vape pens					
Social Media/Phones					
Video Games					
Gambling					
Sex/Pornography					
Other:					

Other Substance use information?

_____

_____

_____

EMOTIONAL/MENTAL HEALTH

Do you presently or have you in the past had any:

Risk Factor	Yes	No	If yes, describe and frequency
Suicidal Thoughts			
History of Suicide Attempts			
Homicidal / Violent Thoughts			
History of Violent Behavior			
Self-Harm			
Paranoid Thoughts			
Hallucinations			
Disorganized Thinking (i.e., flight of ideas, inability to focus, "word vomit and/or can't stop talking")			
Poor reality testing			

SPIRITUAL/RELIGIOUS BELIEFS

Is there any specific belief system that you follow that I need to be aware of? _____

_____

Did religion/spiritual practice play a part in your upbringing? _____

RELATIONSHIP/SEXUALITY

Are you currently in a romantic partnership? Yes No Please describe (length of partnership, is it healthy, not interested in a partnership) _____

_____

_____

Sexual Identify as _____
Gender Identity _____
Preferred Pronouns _____
Prefer Not to Answer _____

TRAUMA and ABUSE SCREENING

Abuse History: **In the past has there been any reports or allegations of:**

Physical Abuse:	Abused	Abuser	None
Sexual Abuse:	Abused	Abuser	None
Emotional Abuse:	Abused	Abuser	None
Neglect:	Abused	Abuser	None
Exploitation	Abused	Abuser	None

Current Abuse Allegations:

Physical Abuse:	Abused	Abuser	None
Sexual Abuse:	Abused	Abuser	None
Emotional Abuse:	Abused	Abuser	None
Neglect:	Abused	Abuser	None
Exploitation	Abused	Abuser	None

Have you experienced any traumas you think we should address?

_____

_____

_____

EDUCATION

Current Level of Education: _____

Educational Goals: _____

School _____ School contact needed? Yes or No

CAREER

Current employment/job description? _____

Employment History? _____

Level of job satisfaction (1-5) _____Why? _____

Any volunteer work? _____

LEGAL HISTORY

Current legal involvement (include probation/court dates)

_____

_____

SUPPORT SYSTEMS

Please describe current support system

_____

_____

_____

SLEEP

On average how many hours? _____

Difficulty falling or staying asleep? _____

Difficulty waking up or staying awake? _____

Use of any sleep aids or substances to aid in sleep? _____

Any noticeable sleep changes in the last month? _____

EATING

Any food restriction? If so how often? _____

Any purging or compensatory behaviors? If so how often? _____

Any binge eating? _____

Engage in eating any nonfood substances? _____

CASE FORMULATION

Presenting Problem: _____

_____

_____

_____

_____

_____

Precipitating Factors: _____

_____

_____

_____

_____

_____

Predisposing Factors: _____

_____

_____

_____

_____

_____

Perpetuating Factors: _____

Protective Factors: _____

Treatment needs based on the above formulation? _____

Prognosis: _____

DOCUMENTATION OF CRITERIA FOR PRIMARY DSM V DIAGNOSIS

DSM V DIAGNOSIS: _____