One Step at a Time Counseling Services

Adult

BIO-PSYCHOSOCIAL ASSESSMENT

1. **Gender** _____

2. **INTAKE INFORMATION:**

History of Presenting Problem:_____

_____

_____

Previous Treatment History and/or Diagnostic History (Include diagnoses, treatment information and dates):

Mental Health _____

_____

Substance Abuse _____

_____

Domestic Violence _____

_____

3. **Do you smoke** **YES** ☐ **NO** ☐

If yes how many pack per day? _____

4. **ASSESSMENT/INTERPRETATIVE SUMMARY-CURRENT**

What assets does client have that will help him/her succeed in treatment? _____
_____
_____
_____

Client Name:_____

What are the possible barriers/roadblocks that may hinder client's progress in treatment?

_____

_____

_____

Type of treatment services needed: ☐ individual/Interactive ☐ Family
☐ Rehabilitation/Life Skills ☐ Case Management ☐ Other_____

Frequency of Services: ☐ Once weekly ☐ Twice weekly ☐ Other_____

Preferred Location of Services: ☐ Home ☐ School ☐ Other _____

List any specialized skills, therapeutic knowledge, and/or tools to be provided in order to enhance treatment outcome: _____

Are there any referral to and/or collaboration with another agency? Yes ☐ No ☐
If yes, list name and telephone number _____

Are there any co-occurring disabilities/disorders that will affect treatment? Yes ☐ No ☐
If yes, what are they? _____
If yes, how will they be addressed in treatment? _____
_____

Are there any needs for assistive technology? Yes ☐ No ☐
If yes, how will they be addressed in treatment? _____
_____

Other pertinent information: _____
_____

5. HEALTH HISTORY/CURRENT BIOMEDICAL CONDITIONS

Any current medical/health problems? ☐ Yes ☐ No
If yes, what is the diagnosis/problem(s)? _____
_____

_____

Client Name:_____

If applicable-What treatment are you receiving? _____
_____
_____

Do you have an advanced directive? ☐ Yes ☐ No
If so, how will it impact your treatment? _____
_____
_____

Any disabilities that would affect your treatment? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

Any allergies to medication? ☐ Yes ☐ No
If, yes list medications _____
_____
_____
_____

Personal physician _____

Are you currently taking prescribed or over the counter medication? ☐ Yes ☐ No
If yes, list medications below:

Medication	Physician	Strength/Dosage	Date Initiated

(List additional medications on additional pages)

How have you adjusted to treatment/medication? _____
_____
_____

Client Name:_____

What present or past medications were effective? Not effective? _____
_____
_____
_____
_____
_____

6. HISTORY OF VIOLENT BEHAVIOR/SUICIDAL TENDENCIES

Do you have a history of violent behavior? ☐ Yes ☐ No
If yes, describe and include dates _____
_____
_____

Have you ever attempted suicide? ☐ Yes ☐ No
If yes, describe and include dates _____
_____
_____

DOMESTIC VIOLENCE/SEXUAL ASSUALT

Have you ever been a victim or witnessed of emotional abuse and/or neglect ☐ Yes ☐ No
If yes, describe: _____
_____
_____

Have you ever been a victim or witnessed of domestic violence and/or neglect ☐ Yes ☐ No
If yes, describe: _____
_____
_____

Have you ever been a victim or witnessed of sexual assault and/or neglect? ☐ Yes ☐ No
If yes, describe: _____
_____
_____

Who was the perpetrator? _____
Any resolve? Please explain: _____

Have you received counseling for sexual assault/abuse? ☐ Yes ☐ No

Client Name:_____

If yes, describe: _____

How recent or how long ago?_____

Do you feel this has helped you? ☐ Yes ☐ No

7. FAMILY/MARITAL, SOCIAL HISTORY, LIVING SITUATION

Family Member/Name	Age	City/State	Current Relationship
Father			
Mother			
Sister			
Brothers			
Spouse			
Children			

With whom do you currently live?_____ Number in Home _____

Current Living Environment: _____ House _____ Apt __ Duplex _____ Other _____

Who have you lived within the past? _____

Any significant childhood losses? Include divorce, death and estrangement. _____

_____

_____

Age of loss(es) _____

Any history of alcohol/drug abuse or mental illness in family or origin? ☐ Yes ☐ No

If yes, list family members (s) _____

Client Name:_____

Have any family member been treated for any of the above? ☐ Yes ☐ No
If yes, list family member(s) _____
_____
_____

Significant other relationships: List year and length of relationship or marriage, year of separation or divorce, number of children: _____
_____
_____

Does significant other drink or use drugs? ☐ Yes ☐ No ☐ N/A

8. EDUCATIONAL HISTORY

Last year _____Name of school _____

Can you read and write? ☐ Yes ☐ No

Have you been diagnosed with a learning disability? ☐ Yes ☐ No

Do you have any difficulty reading? ☐ Yes ☐ No

Do you have any difficulty writing? ☐ Yes ☐ No

Which grades, if any did you repeat? _____

Which vocational school or college have you attended? _____

List specialized training, if any _____

List and describe any suspensions or expulsions _____

9. CULTURAL/RELIGIOUS ORIENTATION

What is your race or ethnicity? ☐ Caucasian ☐ African American ☐ Asian
☐ Hispanic ☐ Native American ☐ Other _____

How will your cultural practices affect treatment? _____
_____
_____

What is your religious background? ☐ Protestant ☐ Jewish ☐ Catholic
☐ Other ☐ None

Does client attend church on a regular basis? ☐ Yes ☐ No

Spiritual beliefs and practice of same? _____

Are you a U.S. citizen? ☐ Yes ☐ No
If no, how long have you been in the U.S.? _____

10.OCCUPATIONAL/MILITARY HISTORY (clients 16 years +) N/A ☐

Employer _____ Job Title _____
Employer's address _____ How long employed? _____
Employer's phone number _____How long employed? _____
Other sources of income (ie.e. SSI, disability, VA, retirement, child support, etc):
_____
_____
_____

Previous employment:
Employer Dates Title Reason for leaving
_____
_____
_____

What types of work are you qualified to perform? _____
_____
_____

Have you ever been in the military? ☐ Yes ☐ No
If yes, what branch, dates of service and type of discharge. _____
_____
_____

11.SEXUAL HISTORY

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
If yes, what form(s) of protection and/or birth control do you use? _____
_____
_____

Are you currently sexually active? ☐ Yes ☐ No
If yes, details of what, when, etc. _____
_____
_____

Do you desire help obtaining services for infection screening? ☐ Yes ☐ No
If yes, note counselor's report of action taken to assure the request services: _____
_____
_____

Sexual orientation: _____

12.RECREATIONAL/LEISURE HISTORY

What do you currently like to do for recreation? _____

How have spent your leisure time in the past? _____

13. LEGAL HISTORY

What is your legal status? _____
_____

List chronologically any past convictions:

Offense	Felony/Misdemeanor	Age	Sentence	Jail Time

14. **ECONOMIC RESOURCES**

Do you own a home? ☐ Yes ☐ No Do you rent a home? ☐ Yes ☐ No

Do you own a car? ☐ Yes ☐ No

How do you currently support yourself and your family financially? _____
_____
_____

15. CURRENT SUPPORT SYSTEM

To whom do you currently look for support? _____
_____
_____

Do they support your entering treatment? ☐ Yes ☐ No

Are you experiencing severe isolation or withdrawal from social contact? ☐ Yes ☐ No
If yes, explain: _____
_____
_____

16. CLIENT'S QUALITIES (client responses needed)

What are your strengths/abilities? (assets, resources, natural positives) _____
_____
_____
_____

What are your needs/interests? (weakness, what do you need to recover) _____
_____
_____
_____

What are abilities/interests? (skills, aptitudes, capabilities talents, competencies) _____
_____
_____
_____

What are your preferences? (what will enhance treatment experience)? _____
_____
_____
_____

What do you expect from this program in terms of service? _____
_____
_____
_____

_____ _____

Therapist's signature/credentials Date

Client Name:_____