Empower Wellness

ADULT BIOPSYCHOSOCIAL ASSESSMENT

Please use Blue or Black Ink Only

Demographics

Client Name:	Date:
Current Address: City/State: Zip Code:	Phone #:
Date of Birth:	Marital/Relationship Status:
Ethnicity:	
Primary Language Spoken:	Secondary Language:
Referral Source:	Phone:
Emergency Contact:	Phone:

Family Relationships

Does the client have any children?					
Name	Date of Birth	Sex	Custody? Yes or No	Lives With?	Additional Information

Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)				
Name	Age	Sex	Relationship	Additional Information
Primary Language of household/family:				Secondary Language:

Family History

Family History of (select all that apply):						
	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol/Substance Abuse:	☐	☐	☐	☐	☐	☐
History of Completed Suicide:	☐	☐	☐	☐	☐	☐
History of Mental Illness/Problems Such as:						
Alzheimer's Disease/Dementia	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Attention-Deficit/Hyperactiv ty	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Incarceration	☐	☐	☐	☐	☐	☐
Learning Disorders	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
School Behavior Problems	☐	☐	☐	☐	☐	☐
Other:						

Client's/Family's Presentation of the Problem:
Client's/Family's Expected Outcome:

Physical Functioning

Allergies (Medication & Other):
Current Medical Conditions:
Surgeries:
Current Medications (include vitamins, herbs, and over-the-counter):
Past Medications:

Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including residential treatment centers, group homes, therapeutic foster care, aftercare, inpatient psychiatric hospitalizations, and outpatient medication treatment/therapy):

Dates:	Inpatient/Outpatien:	Location	Reason	Completed? Y/N

Pain Questionnaire

Pain Management: Are you currently in pain now? ☐ YES ☐ NO
If yes, please state location of your pain and rate your pain on a scale of 1-10 (with 10 being the most severe) and write your score here:

Are you currently receiving care for the pain? ☐ YES ☐ NO
If no, would you like a referral for pain management? ☐ YES ☐ NO

Nutrition

Appetite: ☐ GOOD ☐ FAIR ☐ POOR Select all that apply:

☐ Recently gained/lost significant weight	☐ Binges/overeats to excess
☐ Restricts food/Vomits/over-exercises to avoid weight gain	☐ Special dietary needs
☐ Hiding/Hoarding Food	☐ Food allergies

Comments:

During pregnancy, did your mother or if child (you) use any of the following (select all that apply)?

☐ TOBACCO	☐ ALCOHOL	☐ STREET DRUGS	☐ UNKNOWN

Comments (frequency and intensity of use, participation in treatment, birth defects or malformations due to drug/alcohol use among siblings?

Any problems labor and/or delivery? Apgar Scores?

Developmental Milestones- please select any that were done late or if patient is child, is still having trouble with:		
☐ Rolling Over (2-6 months)	☐ Sitting (6-12 months)	☐ Standing (8-16 months)
☐ Walking (8-16 months)	☐ Engaging peers (24-36 months)	☐ Toileting (24-36 months)
☐ Dressing self (24-36 months)	☐ Feeding self	☐ Sleeping alone
☐ Tolerating Separation	☐ Playing cooperatively	☐ Speaking

Are immunizations up to date? ☐ YES ☐ NO

Has the client had any of the following (select all that apply)?

Blood Disorder:	☐ Anemia	☐ Bleeding	☐ Bruising	
Brain Disorders:	☐ Confusion	☐ Headaches	☐ Coordination Problems	
	☐ Muscle Weakness	☐ Staring	☐ Tremors	
	☐ Tic (motor/vocal)	☐ Head Injuries	☐ Seizures	Last seizure:
GI Problems:	☐ Constipation	☐ Diarrhea	☐ Incontinence	☐ Vomiting
Heart/Lung Problems:	☐ Asthma	☐ Chest Pain	☐ Murmur	☐ Surgery ☐ Congenital Heart Disease
Hormone Problems:	☐ Obesity	☐ Thyroid	☐ Early Puberty	☐ Late Puberty
Infections:	☐ Chicken Pox	☐ Measles	☐ Sinus Infections	
☐ Covid-19Infections	☐ Meningitis	☐ Whooping Cough	☐ Encephalitis	
☐ Mumps	☐ High Fevers	☐ Pneumonia	☐ Covid-19 ☐ Other	
Injuries:	☐ Broken Bones	☐ Stitches	☐ Other	
Kidney Problems:	☐ Bed Wetting	☐ Daytime Wetting	☐ Infections	
Muscle/Bone Problems:	☐ Scoliosis	☐ Spasticity	☐ Other:	
Poisoning:	☐ Chemicals	☐ Lead	☐ Other	
Sensory Problems:	☐ Hearing	☐ Tactile (feeling)	☐ Vision	
Sexual Problems:	☐ Birth Control	☐ Masturbation	☐ Promiscuity	☐ Erectile Dysfunction
Skin Disorders:	☐ Acne	☐ Birthmarks	☐ Eczema	☐ Hair Loss

Social

Supportive Social Network? (Rate the network using a scale of 1 Weak to 5 Strong)			
Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	

Living Situation:			
☐ Housing Adequate	☐ Housing Dangerous	☐ Housing Overcrowded	☐ Homeless
☐ Dependent Upon Others	☐ Incarcerated	☐ Ward of State/Tribal Court	
Additional Information:			

Employment: Are you currently employed?			
YES	Employer:	Length of Employment:	
☐ Satisfied	☐ Not Satisfied	☐ Supervisor Conflict	☐ Co-worker Conflict
NO	Last Employer:	Reason for Leaving:	
☐ Never Employed	☐ Disabled	☐ Student	☐ Unstable Work History

Family Financial Situation:		
☐ No Current Problems	☐ Large Indebtedness	☐ Relationship Conflicts Over Finances
☐ Impulsive Spending	☐ Poverty of Below	☐ Financial Difficulties

Legal Status Screening

Past or current legal problems (select all that apply)		
☐ None	☐ Parole	☐ Probation
☐ Arrests	☐ Conviction	☐ DUI/DWI
☐ Jail	☐ Prison	☐ Detention Center
☐ Gangs	☐ Other	

If yes to any of the above, please explain: ☐ YES ☐ NO		
Any court-ordered treatment? Please explain below.		
Ordered By	Offense	Length of Time

Leisure & Recreation

Which of the following does the client do? (Select all that apply).	
☐ Spend time with friends	☐ Sports/exercises
☐ Classes	☐ Dancing
☐ Spending time with family	☐ Hobbies
☐ Work part-time	☐ Watch movies/television
☐ Go "downtown"	☐ Stay at home
☐ Listen to music	☐ Go to casinos
☐ Spent time at clubs/bars	☐ Other:
What limits the client's leisure/recreational activities?	

Functional Assessment

Is client able to care for him/herself? ☐ YES ☐ NO If no, please explain:			
Uses or needs assistive or adaptive device (Select all that apply)			
☐ None	☐ Glasses	☐ Walker	☐ Braille
☐ Hearing Aids	☐ Cane	☐ Crutches	☐ Wheelchair
☐ Translated Written Information	☐ Translator for Speaking	☐ Other:	

Psychological

History of Depressed Mood? ☐ YES ☐ NO If yes, were you professionally diagnosed by a psychiatrist and when? If no, what time period were you depressed?		
History of irritability, anger, or violence (tantrums, hurt others, cruelty to animals, destroy property):		
Sleep Pattern: Number of hours per day Time to onset of sleep falling asleep # of awakenings?		
☐ Normal	☐ Sleeping too much	☐ Sleeping too little
Energy Level: ☐ Normal ☐ Low ☐ Average ☐ High		
History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal?) Select all that apply:		
☐ Intrusive memories, thoughts, perceptions	☐ Nightmares	☐ Flashbacks
☐ Avoiding thoughts, feelings, conversations	☐ Poor sleep	☐ Irritability
☐ Hypervigilance	☐ Other:	
Any additional information:		

Bereavement/Loss & Spiritual Awareness: List significant losses, deaths, abandonments, & traumatic incidents

Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, abandonments, traumatic incidents: If yes, please explain			
Has client been abused at any time in the past or present by family, significant others, or anyone else? ☐ NO ☐ YES, Explain:			
Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal putdowns			☐ YES ☐ NO
Being threatened			☐ YES ☐ NO
Made to feel afraid			☐ YES ☐ NO
Pushed			☐ YES ☐ NO
Shoved			☐ YES ☐ NO
Slapped			☐ YES ☐ NO
Kicked			☐ YES ☐ NO
Strangled			☐ YES ☐ NO
Hit			☐ YES ☐ NO
Forced or coerced into sexual activity			☐ YES ☐ NO
Other			☐ YES ☐ NO
Was it reported? ☐ YES ☐ NO		To whom?	
Has client ever witnessed abuse or family violence? ☐ No ☐ Yes, explain:			

Behavioral Assessment

Abuse/Addiction- Chemical and Behavioral				
DRUG	Age First Used	Age Heaviest Use	Recent Pattern of Use (frequency, amount, how used)	Date Last Used
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, speed, amphetamines, etc.)				
Methamphetamines				
Inhalants (gas, paint, glue, whip its), etc.				
Hallucinogens, LSD, PCP, mushrooms, etc.				
Opioids (narcotics, heroin, methadone, suboxone, etc.)				

Sedative/Hypnotics (Valium, Xanax, Phenobarb., etc.				
Designer Drugs/Other (herbal, steroids, cough syrup, Kratom, etc.)				
Tobacco (smoke, chew, vape)				
Caffeine				

Ever injected drugs? ☐ YES ☐ NO If yes, which ones?			
Drug of choice?			
Consequences as a Result of Drug/Alcohol Use (select all that apply)			
☐ Hangovers	☐ DTs/Shakes	☐ Blackouts	☐ Binges
☐ Overdoses	☐ Increased Tolerance (need more to get high)	☐ Gastrointestinal Bleeds	☐ Liver Disease
☐ Sleep Problems	☐ Seizures	☐ Relationship Problems	☐ Quit School
☐ Lost Job	☐ DUI/DWI's	☐ Assaults	☐ Arrests
☐ Incarcerations	☐ Homicide	☐ Other:	
Longest Sober Period of Sobriety?		**How long ago?**	
Triggers to use (list all that apply):			
Have you traded sex for drugs? ☐ NO ☐ YES, explain:			
Have you been tested for HIV? ☐ YES ☐ NO If yes, date of last test: Results:			
Risk Taking/Impulsive Behaviors (current/past) – select all that apply:			
☐ Unprotected sex	☐ Shoplifting	☐ Reckless driving	
☐ Gang Involvement	☐ Drug Dealing	☐ Carrying/using weapon	
☐ Other:			