

BIOPSYCHOSOCIAL ASSESSMENT – ADULT

Today's Date _____	Name _____
Date of Birth _____	Email Address _____
Preferred Language _____	Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete this form in its entirety. If you wish not to disclose personal information, please check "No Answer" (NA).

PRESENTING PROBLEM

1. Please describe what brings you in today? _____
2. How long have you been experiencing this problem? ☐ Less than 30 day ☐ 1-6 months ☐ 1-5 years ☐ 5+ years
3. Rate the intensity of the problem 1 to 5 (1 being mild and 5 being severe): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
4. How is the problem interfering with your day-to-day functioning? _____
5. What are your current goals for therapy? If treatment were to be successful, what would be different?

6. Are you currently or in the last 30 days experienced any of the following symptoms? (check all that apply)

<input type="checkbox"/> Sadness	<input type="checkbox"/> Hopeless/Helpless	<input type="checkbox"/> Sleep Too Much	<input type="checkbox"/> Fatigue/No Energy	<input type="checkbox"/> Poor Memory
<input type="checkbox"/> No Motivation	<input type="checkbox"/> Lack of Interest	<input type="checkbox"/> Thoughts of Dying	<input type="checkbox"/> Guilt	<input type="checkbox"/> Feel Worthless
<input type="checkbox"/> Not Hungry	<input type="checkbox"/> Prefer Being Alone	<input type="checkbox"/> Irritable/Angry	<input type="checkbox"/> Can't Sleep	<input type="checkbox"/> Too Much Energy
<input type="checkbox"/> No Need for Sleep	<input type="checkbox"/> Talk Too Fast	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Can't Concentrate	<input type="checkbox"/> Restless/Can't Sit Still
<input type="checkbox"/> Suspicious	<input type="checkbox"/> Hearing Things	<input type="checkbox"/> Seeing Things	<input type="checkbox"/> Have Special Powers	<input type="checkbox"/> People Watching Me
<input type="checkbox"/> People Out to Get Me	<input type="checkbox"/> Feeling Nervous	<input type="checkbox"/> Fearful	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Can't be in Crowds
<input type="checkbox"/> Easily Startled	<input type="checkbox"/> Avoidance	<input type="checkbox"/> Re-occurring Nightmares		

7. Do you now or have you ever contemplated suicide?.....
8. Are you a survivor of trauma?.....
9. Are you pregnant now?.....
10. If yes, when are you due? (day/month/year) _____
11. Are you at risk for HIV/AIDS/Sexually Transmitted Diseases (unsafe sex, using needles?)
12. Please list allergies to medications or food: _____

13. Has your physical health kept you from participating in activities?.....

	Yes	No	NA
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For staff use only:

Client Name: _____ Client Number: _____

TOBACCO1. Have you ever used any forms of tobacco (cigarettes, snuff, etc.)? **IF NO SKIP TO NEXT SECTION****SECTION**

2. Are you a former tobacco user?.....

3. If yes, what form(s) of tobacco have you used in the past (please check all that apply)

☐ Cigarettes ☐ Cigars ☐ Snuff ☐ Chewing Tobacco ☐ Snuff ☐ Other

4. How many times on an average day do you use tobacco (1-99)?

Cigarettes _____ Cigars _____ Snuff _____ Chewing Tobacco _____ Snuff _____

5. Have you been involved in a program to help you quit using tobacco in the past 30 days?.....

6. If so, which self-help group was used?.....

Yes No NA

1. ☐ ☐ ☐2. ☐ ☐ ☐5. ☐ ☐ ☐**SUBSTANCE USE/ADDICTION PRESENT**

1. Would you or someone you know say you are having a problem with alcohol?.....

2. Would you or someone you know say you are having problems with pills or illegal drugs?.....

3. Would you or someone you know say you are having problems with other addictions, ie. gambling, pornography or shopping?.....

4. Have you ever been to a self-help group?.....

Yes No NA

1. ☐ ☐ ☐2. ☐ ☐ ☐3. ☐ ☐ ☐4. ☐ ☐ ☐**SUBSTANCE USE/ADDICTION PAST**

1. Would you or someone you know say you had a problem with alcohol?.....

2. Would you or someone you know say you had problems with pills or illegal drugs?.....

3. Would you or someone you know say you had problems with other addictions, ie. gambling, pornography or shopping?.....

4. Is there a family history of addiction in your family?.....

5. If yes, please describe:.....

Yes No NA

1. ☐ ☐ ☐2. ☐ ☐ ☐3. ☐ ☐ ☐4. ☐ ☐ ☐**PERSONAL, FAMILY AND RELATIONSHIPS**

1. Who is in your family? (parents, brothers, sisters, children, etc.).....

2. Has there been any significant person or family member enter or leave your life in the last 90 days?.....

Yes No NA

2. ☐ ☐ ☐

3. How are the relationships in your family?.....

4. How are the relationships in your support system (friends, extended family, et.?).....

Good Fair Poor Close Stressful Distant Other

☐ ☐ ☐ ☐ ☐ ☐ ☐☐ ☐ ☐ ☐ ☐ ☐ ☐

Conflict Abuse Stress Loss Other

☐ ☐ ☐ ☐ ☐☐ ☐ ☐ ☐ ☐☐ ☐ ☐ ☐ ☐☐ ☐ ☐ ☐ ☐

5. Are there any problems in your family now? (check all that apply).....

6. Were there any problems with your family in the past? (check all that apply).....

7. Are there any problems in your support system now? (check all that apply).....

8. Were there any problems with your support system in the past? (check all that apply).....

9. What is your marital status now? ☐ Single ☐ Married ☐ Living as Married ☐ Divorced
☐ Widowed ☐ Never Married**For staff use only:**

Client Name: _____ Client Number: _____

- | | Yes | No | NA |
|---|------------------------------|--------------------------|--------------------------|
| 10. Have you ever had problems with marriage/relationships?..... | 10. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. If yes, please check why <input type="checkbox"/> Stress <input type="checkbox"/> Conflict <input type="checkbox"/> Loss <input type="checkbox"/> Divorced/Separation
<input type="checkbox"/> Trust Issues <input type="checkbox"/> Other _____ | | | |
| 12. Do you have any close friends?..... | 12. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have problems with friendships?..... | 13. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you get along well with others (neighbors, co-workers, etc.)?..... | 14. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. What do you like to do for fun? _____ | | | |

EDUCATION

- | | Yes | No | NA |
|---|-----------------------------|--------------------------|--------------------------|
| 1. What is the highest grad you completed in school? (please check)
<input type="checkbox"/> No Education <input type="checkbox"/> K-5 <input type="checkbox"/> 6-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> GED <input type="checkbox"/> College Degree <input type="checkbox"/> Masters Degree | | | |
| 2. Would you describe your school experience as positive or negative? _____ | | | |
| 3. Are you currently in school or a training program?..... | 3. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

LEGAL

- | | Yes | No | NA |
|---|------------------------------|--------------------------|--------------------------|
| 1. Have you ever been arrested? IF NO SKIP TO NEXT SECTION..... | 1. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. In the past month?..... | 2. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If yes, how many times? _____ | | | |
| 4. In the past year?..... | 4. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. If yes, how many times? _____ | | | |
| 6. If yes, what were you arrested for? _____ | | | |
| 7. What was the name of your attorney? _____ | | | |
| 8. Were you ever sentenced for a crime?..... | 8. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. If yes, number of prison sentences served? _____ | | | |
| 10. What year(s) did this occur? _____ | | | |
| 11. Are you currently or have you ever been on probation or parole?..... | 11. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. If yes, what is the name of your attorney or probation officer? _____ | | | |

WORK

- | | Yes | No | NA |
|---|-----------------------------|--------------------------|--------------------------|
| 1. What is your work history like? <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Sporadic <input type="checkbox"/> Other | | | |
| 2. How long do you normally keep a job? <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years | | | |
| 3. Are you retired?..... | 3. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. If yes, what kind of work do you do/did you do in the past? _____ | | | |
| 5. Have you ever served in the military?..... | 5. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. If yes, are you <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Other | | | |

MEDICAL

- Current Primary Care Physician: _____ Phone _____
- Past and Current Medical/Surgical Problems: _____
- Past and Current Medications and Dosages: _____
- Have you seen a Mental Health Professional Before? ☐ Yes ☐ No
- If yes, Name, When, and Reason for Changing: _____
- Current Psychiatrist/APRN, if applicable: _____
- Is there anything else you would like me to know about you? _____

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