KIM MILLER COUNSELING
BIO-PSYCHOSOCIAL ASSESSMENT

Kim Miller Counseling wishes to provide you with the best services possible. In order to do so we need to obtain the following information. This information will be used to assist in treatment planning. Your assigned therapist will review this information with you to help develop your Recovery Plan.

Please be aware that this information is confidential with the following exceptions: (1) if you sign a Release of Information form; (2) upon receipt of a court order by a judge; (3) in the event of a valid emergency; (4) if you commit a crime at the session or against any person at the counseling office, or threaten to commit such a crime; or (5) upon suspicion of abuse or neglect of a child or elderly person; (6) upon receipt of a request that may be governed by Arizona Statutes, such as Workers Compensation (7) admission of desire to harm oneself or someone else.
Unless otherwise noted, all questions should be answered regarding the person who will be receiving services (for example: your child).

Intake Page for Identifying Data	**Notes**

Name of person to receive services: _____ Date: _____

Date of Birth: _____ Home Phone_____ Cell Phone:_____

Email Address_____ Age:_____ Sex:_____

Address:_____

Emergency Contact Name/Phone Number:_____

Psychiatric Medications: Y or N If yes, who is prescribing medications:_____

Any Other Psychological Services You Are Currently Involved in Y or N

Any Psychological Services You Have Used Over the Last Year Y or N

If yes, list names, dates, services rendered:_____

Who referred you to treatment? DSelf D Parents DFamily member DPhysician

DSchool DWork DOther, specify: _____

Presenting Problem

Are you court ordered to enter treatment? DNo DYes (If you are court ordered, please submit a copy of the order.)

What is the main reason that you are seeking services? DDepression DAnxiety

DDrugs/Alcohol DRelationship Issues DEducational DAnger Management

DBehavioral Problems DImpulsivity DOther: _____

How often do these problems occur? _____

How long have you had these problems? _____

Have these problems gotten worse since they began? DNo DYes

Have these problems ever decreased or gone away? DNo DYes

What has occurred in the past month that has caused or increased the problem(s)?

_____

_____

What services are being sought at this time? _____

_____

Family/Developmental History

Was your growth and development as a child/adolescent within normal limits? (explain)

Social Development D Yes D No: _____

Cognitive/Educational D Yes D No: _____

Physical Development D Yes D No: _____

Emotional Development D Yes D No: _____

Number of Marriages: Mother _____ Father _____

Children from previous marriage: Mother _____ Father _____

Date of most recent marriage: Mother _____ Father _____

Date(s) of separation(s): Mother _____ Father _____

If Divorced: How long: _ Custody arrangements at the time:_____

_____

Visitation Schedule: _____

If divorce(s) how well did you adjust: _____

How many times did you move as a child/adolescent: D1-2 D3-5 D5-7 D8+

With whom did you live while growing up? _____

Other households in which you have resided: _____

Were you ever placed in a foster home? DNo DYes

Discipline at home was: DOverly strict DStrict DFair DLenient DNonexistent

Who made the rules and enforced discipline? _____

How often was punishment used? _____

Has law enforcement or other social services agencies been involved in any way with your family? DNo DYes

_____

Educational/Vocational/Employment

In school, what is the highest grade completed? _____

Are you currently in school? DNo DYes Name of school: _____

What types of classroom are/were you in as a child? DRegular DEH DSED DSLD/LD DSpeech DGifted DOther: _____

My grades as a youth were: DExcellent DGood DFair DPoor

My school attendance was: DGood DFair DPoor

Did or do you have any school related problems? DNo DYes Please explain:

_____

Were you ever suspended or expelled from school? DNo DYes

Are/were you more of a leader or a follower with peers? DLeader DFollower

Were you involved in school activities? Like what? _____

Were you ever involved in a gang? DNo DYes

Are you employed? DFull time (35+ hours) DPart time DOther

DNot employed, seeking employment DHomemaker/student/retired/disabled

What do you do at your job? _____

Length of current employment: _____

Previous Employment Please include Job Position and Length in Position:

_____

Support System/Activity Assessment

Whom do you depend upon the most for support? □Parent □Partner □Friend

□Other: _____

Do you have a group of friends outside of your family? □No □Yes

Are you involved in community activities or clubs? □No □Yes

My regular activities include: □School/work □Church □Play □Daycare

□Household chores □Other: _____

What do you do for fun:_____

Medical History/Nutritional Data

Are you allergic to any medications? □No □Yes

If yes, specify medication(s): _____

My energy level is: □Unchanged □Increased □Decreased

Do you have problems with sleep? □No □Yes

What time do you:

go to sleep? _____ am / pm

wake up? _____ am / pm

Do you ever have problems with bedwetting? □No □Yes

After age 5? □No □Yes

Have you ever experienced an injury to your head? □No □Yes

Have you ever experienced any other injuries that effected your life?□No □Yes

Have you ever been in a coma? □No □Yes If so, for how long? _____

Do you have any current medical problems? □No □Yes

If yes, explain: _____

_____

_____

Do you have physical pain? □No □Yes

Are you in pain now? □No □Yes

On a scale from 0 to 10, with 0 being in no pain and 10 being the worst possible pain, how would you rate your pain at this time? (circle) 0 1 2 3 4 5 6 7 8 9 10

Will medical problems or pain interfere in your ability to participate in treatment?

□No □Yes

If yes, explain: _____

Do you feel your medical problems or pains are contributing to the reason you are here?

□No □Yes

If yes, explain: _____

Are you on any type of prescribed medication currently? □No □Yes

If yes, type(s) and dose: _____

_____

Doctor: _____

Reason for use: _____

Are you taking any over-the-counter medications? □No □Yes

If yes, describe: _____

Have you lost or gained more than 10 pounds recently, without trying? □No □Yes

How would you describe your appetite? □Good □Fair □Poor □Other

If other, describe: _____

Sexual Development/History

Are you sexually active? □Yes □No

Age you became sexually active: _____

Do you/have you engaged in behaviors that might place you at risk for sexually transmitted diseases/promiscuous/dangerous behavior patterns: (multiple partners, needle sharing, unprotected sex, etc.)? □No □Yes

Have You Ever Been Pregnant: □Yes □No □Expecting

If yes, how many and at what age: _____

Total number of pregnancies: _____

Have you ever miscarried □No □Yes

Have you ever lost a child □No □Yes

Are sexual behaviors part of the reason you are seeking treatment? □No □Yes

If yes, explain: _____

_____

_____

Cultural Background

Are there any areas of your upbringing or family heritage that would inhibit the treatment process or deserve special acknowledgement? □No □Yes

If yes, specify: _____

Do you think anything in your ethnic background or family heritage could effect the treatment process or influence your current problem(s)? □No □Yes

If yes, explain: _____

_____

What is the primary language you speak at home? _____

Do you speak other languages fluently? □No □Yes If yes, specify: _____

Religious/Spiritual Background

Describe the religious/spiritual tradition you grew up in: _____

_____

Do you attend church? □No □Yes, Affiliation: _____

How would you describe your current spiritual or religious orientation? _____

_____

Are you satisfied with your spiritual life? □No □Yes

Do your religious/spiritual beliefs help you cope with your current problems?

□No □Yes

Overall outlook on life: □Positive □Negative □Neutral □Indifferent

Other: _____

Social/Economic Background

Describe your current living environment (home, neighborhood): _____

_____

_____

The total number of people living in the home is _____

How many are in each of the following groups?

Age 0-17 _____ Age 18-34 _____ Age 35-59 _____ Age 60+ _____

Do you own pets? □No □Yes

If yes, what kind and how many? _____

Legal History

Have you ever been arrested? □No □Yes

Charges: _____

Dates: _____

Outcome: _____

_____

Are you currently involved with the legal system/have charges pending? □No □Yes

If yes, describe: _____

Do you have a probation/parole officer? □No □Yes

If yes, please provide officer's name: _____

Are you currently involved in:

□divorce proceedings □child custody proceedings □bankruptcy proceedings

Others:_____

Behavioral Health History

Ever had any residential or outpatient mental health counseling? □No □Yes

If yes: where did you receive treatment: _____

_____

date(s) of treatment: _____

reason(s) for treatment: _____

Have you taken psychiatric medication in the past? □No □Yes

If yes: Specify type(s): _____

_____

Is there a family history of mental health problems? □No □Yes

If yes: Describe: _____

_____

_____

Substance Abuse History

Alcohol Use:

Have you ever used alcohol? □No □Yes

If yes: type(s) used: _____

Age of first use:____ Age of regular use:____ When was you last use:_____

How often do you currently use: □none □daily □1-3 times per week □4-6 times per week □2 times per month □monthly □other: _____

Is there a family history of excessive use of alcohol? □No □Yes

If yes, how were they related to you? _____

Other Drug Use:

Have you ever abused any type of drugs? □No □Yes

If yes, type(s) used: _____

Age of first use:____ When was your last use:_____

How often do you currently use: □none □daily □1-3 times per wk □4-6 times per wk □2 times per month □monthly □Other:

Is there a family history of drug use? □No □Yes

Questions related to current/past substance use:

Have you ever felt guilty about your alcohol/drug use? □No □Yes

Have you ever experienced memory loss when drinking or using drugs? □No □Yes

Have you ever felt that you should cut down on your alcohol/drug use? □No □Yes

Have you ever felt that you should increase or cut down on drinking or drug use due to feelings of: □Depression □Anxiety □Anger □Paranoia □Hallucinations □Mania □Other: _____

Have you ever used alcohol or drugs to: □Cheer up □Calm down □Steady your nerves □Reduce hallucinations □Feel better □Help cope with emotional problems □Other:

_____

Ever had any outpatient or residential counseling for substance abuse? □No □Yes

If yes, where did you receive treatment: _____

date(s) of substance abuse treatment: _____

reason for substance abuse treatment: _____

Recovery Environment

Is there support for you to participate in treatment? □No □Yes

Is your family environment supportive of you making positive change? □No □Yes

What is your family's expectation of treatment? _____

_____

Will your family be of help to you as you make positive change? □No □Yes

Do you want your family/others to participate in your treatment? □No □Yes

Are they willing to participate? □No □Yes

Abuse History

Have you ever been a victim of:

□emotional abuse/neglect *(examples: screaming and yelling; threatening harm or damage; threats to take away children; punching walls; name calling or humiliation)*

□physical abuse *(examples: slapping, punching, choking, hair pulling, restraining, etc.)*

□sexual abuse *(example: pressured into sexual activity; involved in violent sex)*

□domestic violence OR witness to domestic violence *(Violence by anyone related to the*

client or living with them)

□I have never been a victim of abuse.

Have you ever committed/been accused of committing:

□emotional abuse/neglect *(examples: screaming and yelling; threatening harm or damage; threats to take away children; punching walls; name calling or humiliation)*

□physical abuse *(examples: slapping, punching, choking, hair pulling, restraining, etc.)*

□sexual violence *(example: pressured into sexual activity; involved in violent sex)*

□domestic violence *(Violence by anyone related to the client or living with them)*

□I have never been a perpetrator of abuse.

Risk Behaviors

Have you ever engaged in fire setting? □No □Yes

Have you ever been cruel to animals? □No □Yes

Are you ever afraid that you may physically hurt another person during or after an argument/fight? □No □Yes

Do you own any weapons? □No □Yes

If yes:

What type of weapons? _____

Where are they kept? _____

Have you ever attempted suicide? □No □Yes

When? _____

How? _____

Do you currently have or have you recently had thoughts of harming yourself?

□No □Yes If yes, describe: _____

_____

Have you ever attempted to harm yourself? □No □Yes

When? _____

How? _____

Do you currently have or have you recently had thoughts of harming another?

□No □Yes If yes, describe: _____

_____

Have you ever attempted to harm another? □No □Yes

How? _____

Self Assessment

My memory is: □Good □Fair □Poor

My attention span is: □Good □Fair □Poor

My concentration is: □Good □Fair □Poor

My mood is: □Normal □Sad □Angry □Irritable □Nervous/anxious □Calm

□Other: _____

Do you have any intense fears/phobias? □No □Yes If yes, specify: _____

_____

Have you ever had any auditory, visual or any other type of hallucinations?

□No □Yes If yes, describe: _____

Do you have any behaviors or thoughts that you cannot seem to stop? □No □Yes

If yes, describe: _____

How do your problems impact your family as a whole: _____

_____

What family issues appear to impact your problems: _____

_____

In the past 30 days have you experienced any of the following?

□Worthlessness □Hopelessness □Obsessive guilt □Helplessness

Identify what you see as your strengths: (Check all that apply)

□ Capable of independent living	□Motivated for treatment	□Ability to express feelings
□ Vocational/Occupational skills	□Possible support network	□Ability to stand up for rights
□ Insight/judgment	□Employment	□Ability to make decisions
□ Leisure skills and interest	□Intelligence	□Ability to provide transportation
□ Good physical health	□Education	□Good marital relationship

□ Other: _____

What are some of your other strengths? _____

_____

What are some of your weaknesses? _____

_____

What are the family's expectations for this treatment? _____

_____

_____

Who plans to be involved in treatment? _____

Is there anything else you would like your counselor to know about? □No □Yes

If yes, explain: _____

_____

_____

How Long do you see yourself coming for :_____

Name 3 things you want to work on: _____

Name up to 3 Goals you have: _____

Name up to 3 ways you want to achieve your goals:_____

How often do you want to meet?: _____

_____

Signature of person completing the form

STOP HERE PLEASE

FUNCTIONAL STATUS SUMMARY (Any item checked must be described)

Disoriented
□ Time □ Place □ Person
Describe: _____

Consciousness
□Alert □ Drowsy □ Stupor

Describe: _____

Cognitive/Perceptual
□Auditory Hallucinations □Visual Hallucinations
□Delusions □Phobias
□Loose Associations
□Flight of Ideas □Pressured Speech
□Tangential □Circumstantial
□Obsessions □Compulsions
□Poor attention span □Poor Concentration
□Thought Blocking
□Coherent □Incoherent
□Delirium/Dementia
□Impaired Memory: □Recent □Remote
□Reliable Historian □Unreliable Historian
Describe: _____

Appearance/Behavior
□Unkept □Body Odor
□Neat □Clean □Meticulous
□Slumped □Rigid Posture
□Agitated □Combative □Restless/Fidgety
□Psychomotor Retardation
□Catatonic Rigidity □Waxy Flexibility
□Bizarre Gestures
□Repetitive Acts □Tics
□Tremors □Gait Problems
□Tense □Relaxed
□Overweight □Underweight
□Eye Contact: □Good □Poor

Speech: □Loud □Soft □Slowed □Slurred ☐ Normal

□Manipulative □Controlling □Dramatic
□Guarded □ Defensive □ Appropriate
□Cooperative □Uncooperative □ Inappropriate
Describe: _____

Vegetative Symptoms
□Sleep Disturbance: □Appetite Disturbance
□Weight Loss/Gain Lbs: _____ in _____ weeks/months
□Frequent awakening

Describe: _____

Lethal Thoughts
□Suicidal Ideation □Plan □Intent
□Homicidal Ideation □Plan □Intent
Client Denies: _____

Describe Above: _____

Affect (as observed by interviewer)
□Flat/Blunted/Constricted/Labile □Depressed
□Congruent/Incongruent □Anxious
□Appropriate/Inappropriate □Angry/Irritable
□Euthymic/Broad □Euphoric/Grandiose
Describe: _____

Mood (as reported by client)
□Depressed/Fearful/Anxious □Euphoric/Grandiose
□Angry/Irritable/Rage □Guilt/Shame
□Apathy/Aloof/Lack of Concern
Describe: _____

Judgment
□Poor Impulse Control □Poor Insight
□Irrational □Poor Judgment
Describe: _____

Socialization
□Withdrawn/Isolated □Suspicious/Mistrusting
□Poor Social Skills □Naive/Suggestible
□Emotionally immature □Anhedonia
Describe: _____

_____ _____
Interviewer Date

Bio-Psychosocial Summary and Recommendations

Individual's Long Term View (Describe how individual and/or family sees his/her future in terms of living, education/work, recreation/leisure, and social relationships): _____

Information not obtained at time of Intake (Or other pertinent information, document here): _____

Additional Assessment Needed:
□Psychiatric □Child/Adolescent □Substance Abuse □Abuse and Neglect □ Physical Health Screening □ Daily Living Skills
□ Education/Vocational □Cognitive □Case Management □ Nutrition □ Other_____

Clinical Summary (Summarize <u>all</u> information and address strengths/weaknesses, the impact family dynamics (if applicable) may have on care. Include summary of any additional assessments (if applicable):

_____ □ Continued

Diagnostic Impression: DSM-V

_____ ICD-10_____ ICD-10: _____

_____ ICD-10 _____

_____

Clinical Summary continued:

Qualified Professional/Supervisor Date

The diagnosis and treatment recommendations have been reviewed and appear to be appropriate given the individual's condition at this time.

Staff/Clinician Signature Date

INDIVIDUALIZED TREATMENT PLAN

☐Preliminary ☐Principle

Individual's Stated Goals for Treatment: _____

_____

_____

Problems Identified (write three problems)	**How Problem is to be Addressed** (Indicate if deferred and why)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Identified educational needs: _____

_____

_____

Barriers to Treatment Identified: (check only those that apply)

□Educational limitations □Developmental delays □Lacking Economic Resources □Low Motivation
□Unemployment □Transportation □ Physical Problems □Homelessness
□Limited Family/Social Support □Limited Insight
□Other _____

Treatment Services/Modalities Recommended: (Include service, modality, and frequency. Include external referral):
Weekly Monthly

_____

_____

_____

Criteria for Discharge: _____

_____

_____

Review Date: ☐1 year(maximum): ☐ Other: _____

_____ _____
Client (or Guardian) Signature/Date Clinician Signature/Credentials//Date
I understand the purpose of this Treatment Plan. I was, and will
continue to be, involved in decisions regarding my treatment.

_____
Qualified Professional/Supervisor/ Signature/Credentials/Date
The diagnosis and treatment recommendations have been reviewed and
appear to be appropriate given the individual's condition at this time.