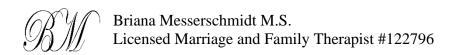


BioPsychoSocial History

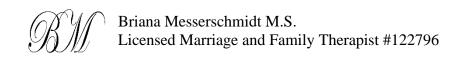
Medical

	Primary Physician and/or Psychiatrist:							
	Please list all medications (including vitamins, herbs, supplements, birth control):							
_								
	Are you happy with your medications? Yes \square No \square							
	Do you believe they are effective? Yes \square No \square							
	How long have you been using them? Yes \square No \square							
	My General Health is: Great \square Good \square Fair \square Not Good \square Poor \square							
	Date of Last Physical:							
	Have you ever had any serious health issues? Yes \square No \square							
	If yes, specify:							
	Have you ever been seriously injured? Yes \square No \square							
	If yes, when and how?							
	Have you ever had a head injury or concussion? Yes \square No \square							
	If yes, when and what?							
	Do you have a history of seizures? Yes \square No \square							
	Have you ever been hospitalized for any reason? Yes \square No \square							
	If yes, when and for what?							
	Are you or are you planning on becoming pregnant? Yes \square No \square							
	Have you noticed a difference in your sleep? Yes \square No \square If so what?							
	Have you noticed a difference in your appetite? Yes \square No \square If so what?							
	Do you drink alcohol? Yes \square No \square							
	If yes, what, how much, and how often?							
	Do you use drugs (recreationally or medicinally)? Yes \square No \square							
	If yes, what, how much, and how often?							
	Do you feel like your drinking or drug use has ever been out of control? Yes \Box No \Box							
	Has a friend for family member ever told you they were concerned about your alcohol or							
	drug use? Yes □ No □							
	Are you in recovery or a 12-step program? Yes \square No \square							
	If yes, Days of Sobriety:							
	Do you have a medical issue you believe the therapist should know about?							
	If yes, what is it and what makes it important?							



Mental Health History

	Have you been in therapy before? Yes \square No \square							
	If yes, where and when?							
Reason:								
	Outcome:							
	Do you have family members with a mental health condition? Yes \square No \square							
	Which member(s) and which condition(s)?							
	$lacksquare$ Have you ever experienced a traumatic event? Yes \Box No \Box							
	If yes, when? Please briefly describe							
	Are there specific events in your life that you keep re-living? Yes \square No \square							
	If yes, please describe							
	Do you have intrusive thoughts which you do not like or feel like are out of control?							
	Yes \square No \square If yes, please describe							
	Have you ever been hospitalized for a psychiatric problem? Yes \square No \square							
	If yes, when and for what?							
	Was this hospital stay voluntary? Yes \square No \square							
	Have you ever attempted suicide? Yes \square No \square							
	If yes, when and how?							
	Have you had any suicidal thoughts:							
	In the last 12 months? Yes \square No \square ; Last 6 months? Yes \square No \square ;, Currently? Yes \square No \square							
	Have you known anyone who committed suicide? Yes \square No \square							
	If yes, what was their relationship to you?							
	Have you ever purposefully hurt yourself without the intention of killing yourself?							
	Yes □ No □							
	If yes, briefly identify how, how often, and when the last time was.							
_								
	Have you had thoughts of harming someone? Yes \square No \square							
_	If yes, did you follow through with your intent? Yes \square No \square							
	Have you had any thoughts of hurting someone:							
	In the last 12 months? Yes \square No \square , Last 6 months? Yes \square No \square , Currently? Yes \square No \square							
	Have you noticed seeing, hearing, or feeling something other people didn't? Yes \Box No \Box							
	If yes, when? Please briefly describe							
	Do you feel as though you ever lose time? Yes \square No \square							
	If so, how often and how much time?							



Relationship and Family History										
	Marital Status Living Arrangement?									
	Are you in a relationship? Yes \square No \square If yes, for how long?									
If in a relations	If in a relationship, what is your partner's name?									
Partner's occu	Partner's occupation:									
Do you find yo	Do you find your relationship satisfying? Yes \square No \square									
If you could change one thing about your relationship what would it be?										
Do you have children? Yes \square No \square										
If yes, list names and ages:										
Have you ever been forced or coerced to do anything sexual? Yes \square No \square										
If yes, please state when and briefly describe:										
\blacksquare Have you ever been afraid of a partner? Yes \square No \square										
If yes, please briefly describe:										
How would yo	How would you describe your relationship with the following people?									
	Great	Good	Fair	Not Good	Poor	N/A				
Mother:										
Father:										
Sister(s):										
Brother(s):										
Children										
Friend(s):										
_	Describe relationships with other significant family members or friends:									
	•		·							
Who is your "s	upport syste	em"?								
Are you satisfice	ed with you	r friendships	? Yes □ No□							
If no please describe:										
	Highest Education Completed/In Progress:									
Course of Stud										
Where are you										
	$lacksquare$ Are you satisfied with your current employment? Yes \Box No \Box									
If no please describe:										
Do you have any legal issues?										
Arrests \square , DUI \square , Probation \square , Convictions \square , Divorce \square , Parole \square , Child custody \square , Other \square :										