Sand Castle Counseling
1890 N. Market St.
Elizabethtown, PA 17022
717.525.0558

Adult Biopsychosocial Assessment
Today's Date: _____

Name: _____ Age: _____
Date of Birth: _____

Presenting Problem

What are the main concerns that bring you to therapy?

_____
_____
_____
_____
_____

How long has this been a concern?

_____
_____
_____

What have you already tried to address the problem?

_____
_____
_____

What do you hope to get from therapy and what are your goals for therapy?

_____
_____
_____
_____

Here is a list of common symptoms – please feel free to circle those that concern you.

Depression/Sadness	Withdrawn	Low Self Esteem	Loss of Interests
Self Injurious Behaviors	Sleep problems	Relationship problems	Change in appetite
Anger Problems/explosiveness	Aggression Towards Others	Drug/Alcohol Use	Sexual issues
Poor Self Control	Domestic violence/family abuse	Job stress/dissatisfaction	Inattentive/Poor Focus
Excessive Fears/Worry/Anxiety	Suicidal thoughts	Hallucinations/Delusions Or Dissociations	Impulsivity
Physical Symptoms	Lying	Family issues	Other:

Traumatic childhood events such as abuse, neglect, and witnessing experiences like crime, parental conflict, mental illness, and substance abuse can result in long-term negative effects on learning, behavior and health (from the ACES study).

Sudden loss of a family member or pet	Frequent moving	Planned or unplanned time away from child	Parental conflict /divorce	Witness to community violence
Natural disasters	Witness to domestic violence	Someone who is chronically, medically ill	Someone who is chronically depressed or suicidal living in the household	Alcohol or drug abuser in the household
Incarcerated family member	Life threatening events or accidents	Physical abuse	Emotional abuse /neglect	Sexual abuse
Financial abuse	Military deployment	Loss of job	Caregiver	

Additional information about circled concerns:

_____

_____

_____

Risk Assessment

Risk Assessment	If yes, please explain
Have you ever had thoughts that you wanted to harm or kill yourself? If yes, are these thoughts that you have had recently?	
Have you ever had thoughts that you wanted to harm or threaten someone else? If yes, are these thoughts that you have had recently?	
Have you ever cut, burned, or injured yourself in a way that was not an accident? If yes, please explain and note if this is a current concern.	
Have you ever intentionally harmed an animal/pet?	
Do you have concerns that you may be using drugs or alcohol in excess?	

Past Counseling/Therapeutic Services/Hospitalizations

Dates received/attended	Provider/Agency	Phone/Address	Diagnosis (if assigned)

Has anyone in your family or extended family ever had therapy before? Yes No Not Known

_____

_____

Family Information

Please list family members that live in the home with you (and pets):

Name	Relationship	Age	Describe their relationship with you.

Other immediate family members that live outside of the home (i.e., parents or siblings):

_____

_____

Are there any custody issues? Yes No

_____

Please circle what is most applicable for you:

- Married
- Single
- Partnered
- Separated
- Divorced
- Widowed

Are there family members or others that you consider part of your support system?

_____

_____

Vocational/Educational History

Highest grade completed: _____

Did you have any learning or behavior problems at school? If yes, please explain.

_____

Are you currently employed? If yes, please explain what you do and if you are working part-time or full-time.

_____

If you are unemployed, what is your primary source of income?

_____

Medical History

Primary Care Doctor or Pediatrician

Name:_____

Address:_____

Phone number:_____

Please list any medications you are taking at this time:

Name of medication	Dosage	Reason for taking	Prescribing Physician

Are you up to date on your vaccinations? Yes No
Date of last physical exam? _____
Have you ever been bitten by a tick? Yes No
Any history of head injuries/surgeries? _____
Please describe any past and/or present medical conditions or serious illnesses:
_____
_____

Are you aware of any sensory processing issues that you have? Yes No (Please describe.)
_____
_____

Are there any extended family members who have been diagnosed with a mental health disorder? Identify family member's relationship to you and the medical condition:
_____
_____
_____

Is there any family use of alcohol or drug abuse? Yes No Unknown (Please describe).
_____
_____

Developmental History

Were kids always a part of your life plan? _____
How many total pregnancies have you had?_____
Any history of infertility, miscarriages, and/or stillborn losses?
_____
Term of pregnancy: _____ months Birth weight:_____

Were there any complications with the pregnancy or delivery? (i.e., time spent in the NICU? Ongoing medical issues as a result?) Yes No Not known (Please describe.)
_____
_____

During pregnancy, was there any use of drugs/alcohol, exposure to domestic violence, major illnesses/accidents, or significant stressors? Yes No Not known (Please describe.)
_____
_____

Are you aware of any delays with developmental milestones? Yes No Not Known
_____

Family of Origin

Who raised you? (Biological parents/grandparents/foster care, etc)

_____
_____

What would it be helpful to know about your childhood, relationship with your parents/siblings, or any other information that may be an underlying cause to this issue?

_____
_____
_____
_____
_____
_____

What age did you become independent from your family of origin?_____

Additional Information

What are some of your strengths and positive qualities? What do other people tell you that your strengths are?

_____
_____
_____

What hobbies/interests do you have? What activities do you like to do?

_____
_____
_____

Do you actively participate in religion/spirituality? Yes No (If yes, where?)

_____

Is there any other information that I should know regarding you or your family?

_____
_____
_____