

BIOPSYCHOSOCIAL ASSESSMENT

Patient Name:

Date of Birth:

Today's Date:

Please complete this form in its entirety.

Presenting Problem

1. Please describe what brings you in today?
2. How long have you been experiencing this problem?
3. Rate the intensity of this problem (1 being mild and 5 being most severe)
4. How is the problem interfering with your daily functioning?
5. What are your current goals for therapy / treatment?

6. If treatment was successful, how would your life be different?

Current Symptoms

7. Are you currently experiencing any of the following symptoms now or in the last 30 days? (Please check all that apply)

- | | | | |
|--|---|--|--------------------------|
| <input type="checkbox"/> <i>Angry / Irritable</i> | <input type="checkbox"/> <i>Have Special Powers</i> | <input type="checkbox"/> <i>Reoccurring Nightmares</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Anxiety</i> | <input type="checkbox"/> <i>Hearing Things</i> | <input type="checkbox"/> <i>Sadness</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Avoidance</i> | <input type="checkbox"/> <i>Helpless</i> | <input type="checkbox"/> <i>Seeing Things</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Can't Be in Crowds</i> | <input type="checkbox"/> <i>Hopeless</i> | <input type="checkbox"/> <i>Self-Esteem Problems</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Can't Concentrate</i> | <input type="checkbox"/> <i>Impulsive</i> | <input type="checkbox"/> <i>Self-Harm</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Depression</i> | <input type="checkbox"/> <i>No Motivation</i> | <input type="checkbox"/> <i>Sleep Changes</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Easily Startled</i> | <input type="checkbox"/> <i>Not Hungry</i> | <input type="checkbox"/> <i>Sleep Too Little</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Fatigue / No Energy</i> | <input type="checkbox"/> <i>No Need for Sleep</i> | <input type="checkbox"/> <i>Sleep Too Much</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Feeling Nervous</i> | <input type="checkbox"/> <i>Panic Attacks</i> | <input type="checkbox"/> <i>Stress</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Feeling Worthless</i> | <input type="checkbox"/> <i>People Out to Get Me</i> | <input type="checkbox"/> <i>Substance Use</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Fearful</i> | <input type="checkbox"/> <i>People Watching Me</i> | <input type="checkbox"/> <i>Suicidal Thoughts</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Food or Eating Changes</i> | <input type="checkbox"/> <i>Poor Memory</i> | <input type="checkbox"/> <i>Suspicious</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Grief and Loss</i> | <input type="checkbox"/> <i>Prefer Being Alone</i> | <input type="checkbox"/> <i>Talk Too Fast</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Guilt</i> | <input type="checkbox"/> <i>Relationship Problems</i> | <input type="checkbox"/> <i>Thoughts of Dying</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Lack of Interest</i> | <input type="checkbox"/> <i>Restless</i> | <input type="checkbox"/> <i>Too Much</i> | <input type="checkbox"/> |

8. Do you now or have you ever contemplated committing suicide? Yes No N/A

9. Are you a survivor of trauma? Yes No N/A

10. Are you pregnant now? Yes No N/A
11. If yes, when are you expecting?
12. Are you at risk for HIV/AIDS/Sexually Transmitted Diseases? (Unsafe Sex / Using Needles?) Yes No N/A
13. Please list all of your allergies to foods or medications

14. Has your physical health prevented you from participating in activities? Yes No N/A

Substance Use

15. Have you ever used any form of tobacco, such as cigarettes, snuff, chewing tobacco, etc.) Yes No N/A
16. Are you a former tobacco user? Yes No N/A

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

- Cigarettes Pipes Cigars Chewing Tobacco
- Snuff Other

17. Have you been in a program to help you quite using tobacco in the last 30 days? Yes No N/A

Substance Use / Addiction Present

18. Would you or someone you know say you are having a problem with alcohol use / addiction? Yes No N/A
19. Would you or someone you know say you are having a problem with pills or illegal drugs? Yes No N/A
20. Would you or someone you know say you are having problems with other addictions, like gambling, pornography, or shopping? Yes No N/A
21. Have you ever been to a self-help group? Yes No N/A

Substance Use / Addiction Past

22. Would you or someone you know say you had a problem with alcohol use or addiction? Yes No N/A
23. Would you or someone you know say you had a problem with pills or illegal drugs? Yes No N/A
24. Would you or someone you know say you had problems with other addictions, like gambling, pornography, or shopping? Yes No N/A
25. Is there a history in your family of addiction Yes No N/A
26. If yes, please describe in more detail:

Personal, Family, and Relationships

27. Have you ever been arrested? Yes No N/A

28. If yes, did you serve time in prison or a corrections facility? Yes No N/A

29. Please list out your family members (parents, children, brothers, sisters, etc.)

30. Does anyone in your family have a history of mental health disorders? Please describe: Yes No N/A

31. Has a significant person or family member entered into your life or left your life in the last 90 days? Yes No N/A

32. How are the relationships with your family members? Please describe:

33. How are the relationships in your support circle (friends, extended family, etc.)? Please describe:

34. Have there been any problems with your family in the past (abuse, conflicts, stress, loss, etc.)? Please describe:

35. Are there any problems with your family now (abuse, conflicts, stress, loss, etc.)? Please describe:

36. Have there been any problems with your support circle in the past? Please describe:

37. Are there any problems with your support circle now? Please describe:

38. What is your marital status now? (Please check all that apply)

Single Married In a Relationship Widowed

Divorced

39. Have you ever had problems in your marriage or relationships? Yes No N/A

40. If yes, please check a reason why:

Abuse Conflict Loss Divorce/Seperated

Trust Issues Infidelity/Cheating Other

41. Do you have any close friends? Yes No N/A

42. Do you have problems being in friendships? Yes No N/A

43. Do you get along well with others (neighbors, co-workers, people around you, etc.)? Yes No N/A

44. What do you like to do for fun / in your spare time? Please explain:

Education

45. Please check the highest level you completed in school:

No Education

K - 5th

6th - 8th

9th - 12th

GED

College Degree

Masters Degree

Advanced Degree

46. Would you describe your schooling experience as a positive? Yes No N/A

47. Are you currently in school or in a training program? Yes No N/A

Work

48. What is your work history like?

Good

Poor

Sporadic

Other

49. How long do you usually stay in your job?

Weeks

Months

About a Year

Longer than 1 year

50. Are you retired from working? Yes No N/A

51. If yes, what kind of work did you do before you retired?

52. Do you feel financially secure? Yes No N/A

53. Have you ever served in the military? Yes No N/A

54. If yes, what is your status?

Active

Reserves

Retired

Other

Medical

55. Who is your current Primary Care Physician?

Phone Number:

56. Past Medical/Surgical Problems:

57. Are you experiencing any medical problems now? Please explain: Yes No N/A

58. Past Medications and Dosages:

59. Are you taking any medications currently and what are the dosages for each? Yes No N/A

60. Have you ever been to a mental health professional before? Yes No N/A

61. If yes, Who: When: Reason for Changing:

62. Current APRN/Psychiatrist, if applicable:

63. Is there anything else you'd like to share with me?