Your Practice's Name Goes Here

BIOPSYCHOSOCIAL SPIRITUAL ASSESSMENT

Patient Name: enter name
Date of Birth: 02/02/02
Today's Date: 10/19/2021

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)

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

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 cigaretttes, 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:

Spirituality and Faith, Belief, Meaning

63. Do you consider yourself spiritual or religious? ☐ *Yes* ☐ *No* ☐ *N/A*

64. Do you have spiritual beliefs that help you cope with stess? ☐ *Yes* ☐ *No* ☐ *N/A*

65. What gives your life meaning?

66. What importance does your faith, belief, or spirituality have in your life?

67. On a scale of 0 (not important at all) to 5 (extremely important), how you would rate the importance of faith, belief, or spirituality in your life?

☐	☐	☐	☐	☐	☐
0	*1*	*2*	*3*	*4*	*5*
not important				*extremely important*	

68. Have your beliefs influenced you in how you handle stress? ☐ *Yes* ☐ *No* ☐ *N/A*

69. What role do your beliefs play in your health care decision making?

70. Are you part of a spiritual or religious community? ☐ *Yes* ☐ *No* ☐ *N/A*

71. Is this community supportive to you and how?

72. Is there a group of people you really love or who are important to you? ☐ *Yes* ☐ *No* ☐ *N/A*

73. If yes, please explain:

74. How would you like your health care provider(s) to use this information about your spirituality as they care for you?

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