Biopsychosocial Assessment

Demographics

Name: _____ DOB: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Preferred Phone: _____

Email: _____ Referred By: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Language Spoken: _____

Marital status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Widowed ☐Separated

Race/ethnicity: ☐Hispanic/Latino ☐African American/Black/African/Caribbean ☐Asian/Pacific Islander

☐Caucasian ☐Native American ☐No Disclosure ☐Other _____

Referral Source & Case Management

Referral Source: _____

Contact Info: _____

_____

Case Manager: _____

Contact Info: _____

Sources of Data

☐ Consultations with collateral contacts _____

☐ Written materials _____

☐ Records from referring agency _____

☐ Diagnostic tests _____

☐ Interviews _____

☐ Observations _____

Client Name: _____

Presenting Problem

Your definition of presenting problem/need:

History of presenting problem:

Your expectations for treatment/service:

Prior attempts to resolve problem:

Length of duration of problem:

☐ Less than 6 mos ☐ 1-6 months ☐ 1-5 years ☐ 5+ years

Severity: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐+

Presenting problem symptoms:

☐ Sadness	☐ Hopeless/helpless	☐ Sleep too much	☐ Fatigue/no energy
☐ No motivation	☐ Lack of interest	☐ Thoughts of dying	☐ Guilt
☐ Not hungry	☐ Prefer being alone	☐ Irritable/angry	☐ Can't sleep
☐ No need for sleep	☐ Talk too fast	☐ Impulsive	☐ Can't concentrate
☐ Suspicious	☐ Hearing things	☐ Seeing things	☐ Feel worthless
☐ Paranoid	☐ Feeling nervous	☐ Fearful	☐ Panic attacks
☐ Easily startled	☐ Avoidance	☐ Re-occurring nightmares	☐ Depression
☐ Decreased appetite	☐ Increased appetite	☐ Poor memory	☐ Anxiety
☐ Restless/can't sit still	☐ People watching me	☐ Can't be in crowds	☐ Mood swings
☐ Headaches	☐ Sexual problems	☐ Fainting	
☐ Dizziness	☐ Skin problems	☐ Nausea	Other:
☐ Chest pains	☐ Rapid heartbeat	☐ Vision changes	
☐ Numbness	☐ Trembling/shaking	☐ Blackouts	
☐ Sweating	☐ Joint/muscle pain	☐ Chills/hot flashes	
☐ Shortness of breath	☐Heart pounding	☐ Stomach aches	

Client Name: _____

Family Composition

Your family members:

Name	Gender	Age	Relationship	Living with You
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Family mental health history:

	Mother	Father	Sister	Brother	Child	Other
Depression	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	
Bipolar Disorder	☐	☐	☐	☐	☐	
Schizophrenia	☐	☐	☐	☐	☐	
ADHD / ADD	☐	☐	☐	☐	☐	
Trauma History	☐	☐	☐	☐	☐	
Abusive Behavior	☐	☐	☐	☐	☐	
Alcohol Abuse	☐	☐	☐	☐	☐	
Drug Abuse	☐	☐	☐	☐	☐	
Suicide	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	

Are you adopted ☐Yes ☐No
Pregnancy history: #Live Births _____ #Stillbirths _____ #Miscarriages _____

Experienced the loss of a child:
Recent loss/bereavement: _____

☐ Family member ☐ Friend ☐ Health ☐ Income ☐ Housing ☐ Relationship ☐ Pet ☐ Job

Client Name: _____

Background & Current Functioning

Living situation:
☐ Adequate housing ☐ Housing dangerous ☐ Ward of the State ☐ Dependent on others ☐ Homeless
☐ Housing overcrowded ☐ Incarcerated ☐ At risk of homelessness ☐ Other: _____

Education/work history:
Years of Education _____ Degree(s) _____
Currently Employed ☐ Yes ☐ No ☐ Satisfied ☐ Unsatisfied Been Fired ☐ Yes ☐ No
☐ Full-time ☐ Seasonal ☐ Self-employed ☐ Part-time ☐ Temporary
☐ Never employed ☐ Disabled ☐ Student ☐ Unstable work history
☐ ☐ Problems with co-workers ☐ Other: _____

Financial situation:
☐ No current problems ☐ Substantial debt ☐ Relationship conflicts over finances
☐ Impulsive spending ☐ Poverty or below
☐ _____

Sources of income:
☐ Employment ☐ Public assistance ☐ Retirement ☐ SSD ☐ SSDI ☐ SSI ☐ Medical disability
☐ Other: _____

Military history:
Branch of service _____ Combat ☐ Yes ☐ No
Type of discharge ☐ Honorable ☐ Dishonorable ☐ Medical ☐ Other than honorable ☐ General
Overall perspective of time in service:

List of current disability status and services you are receiving from the Veterans Administration:

Sexual orientation:

Experienced stress or harassment due to sexual orientation ☐ Yes ☐ No

Client Name: _____

Background & Current Functioning - Cont.

Legal situation:
Past or current legal problems ☐ Yes ☐ No
☐ DUI/DWI ☐ Gangs ☐ Detention ☐ Arrest ☐ Conviction ☐ Jail ☐ Probation ☐ Prison
Explanation:

Court ordered treatment:

Ordered By	Offense	Length of Time

Religious or spiritual involvement:

Leisure & recreation:
☐ Reading ☐ Time with friends ☐ Sports/exercise ☐ Dancing ☐ Hobbies ☐ Watch TV/movies
☐ Time with family ☐ Classes ☐ Walking ☐ Stay at home ☐ Bars/clubs ☐ Listen to music
☐ _____
Limitations you may have in participating in leisure or recreational activities:

Social history & support:
Parents divorced? ☐Yes ☐No
Briefly describe your childhood (happy, chaotic, troubled):

Client Name: _____

Background & Current Functioning - Cont.

Are childhood events contributing to current problems ☐ Yes ☐ No

Satisfied with current family life ☐ Satisfied ☐ Unsatisfied
Satisfied with the support received from family and friends ☐ Satisfied ☐ Unsatisfied
Satisfied with quality of life ☐ Satisfied ☐ Unsatisfied

Strengths/Resources/Supports
What do you feel you do well?

What resources do you have to help with current problem?

What are you (and your family) already doing to improve the current situation?

Who can you count on for support?

Strengths/Resources 1 = Adequate, 2 = Above Average, 3 = Exceptional

--	Family support	--	Social support systems	--	Relationship stability
--	Intellectual/cognitive skills	--	Coping skills & resiliency	--	Parenting skills
--	Socio-economic stability	--	Communication skills	--	Insight & sensitivity
--	Maturity & judgment skills	--	Motivation for help	--	_____

Notes:

Client Name: _____

Medical Background

Primary Care Provider: _____ Phone: _____

Medications:

Name Of Drug	Dosage	Purpose	Frequency	Prescribed By	Began Taking

Surgeries:

Type of Surgery	Date

Physical pain:
Experiencing pain ☐Yes ☐No
Location of pain _____
How long _____
Medication for pain _____
Pain level today ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐+

Nutrition concerns:
Weight _____ Height _____ Appetite ☐Good ☐Fair ☐Poor
Have you practiced these behaviors?
Purge ☐Yes ☐No Notes:
Restrict ☐Yes ☐No
Overeat ☐Yes ☐No
Binge ☐Yes ☐No
Hoarding ☐Yes ☐No

Client Name: _____

Psychiatric & Psychological History

Hospitalizations for mental health purposes ☐ Yes ☐ No

Year	Reason

Presently seeing a therapist/psychiatrist/psychologist ☐ Yes ☐ No

Trauma:

☐ Physical abuse ☐ Sexual abuse ☐ Elder abuse ☐ Adult molested as a child ☐ Robbery victim
☐ Assault victim ☐ Dating violence ☐ Domestic Violence ☐ Human trafficking ☐ Survivor of homicide
☐ PTSD ☐ Rape victim ☐ Victim of stalker ☐ Car accident ☐ Other _____

Abuse/neglect history:

Have you been abused or assaulted ☐Yes ☐No Are you in danger now ☐Yes ☐No

Type of Abuse	By Whom	What Age	Was it Reported
Sexual			☐ Yes ☐ No
Physical			☐ Yes ☐ No
Emotional			☐ Yes ☐ No
Verbal			☐ Yes ☐ No
Abandoned			☐ Yes ☐ No
Neglected			☐ Yes ☐ No

Notes:

Client Name: _____

Psychiatric & Psychological History - Cont.

Your history of violence:

Type of Abuse	Explanation	What Age	Was it Reported
Sexual			☐ Yes ☐ No
Physical			☐ Yes ☐ No
Emotional			☐ Yes ☐ No
Verbal			☐ Yes ☐ No
Abandoned			☐ Yes ☐ No
Neglected			☐ Yes ☐ No

Notes:

Chemical abuse/use:

Drug	Used	Age First Used	Age Heaviest Use	Frequency & Amount	Date Last Used
Alcohol					
Cannabis/marijuana					
Cocaine					
Stimulants					
Methamphetamine					
Hallucinogens					
Opioids					
Sedatives					
Designer Drugs					
Tobacco					
Caffeine					

Drug of choice: _____

Ever injected drugs ☐ Yes ☐ No If yes, which ones _____

Client Name: _____

Psychiatric & Psychological History - Cont.

Consequences of drug/alcohol use:

			Notes:
☐ Sleep problems	☐ Seizures	☐ Binges	
☐ Hangover	☐ DUI's	☐ Liver disease	
☐ Overdose	☐ Homicide	☐ School dropout	
☐ Lost job	☐ Violent	☐ Arrests	
☐ Incarcerations	☐ Blackouts	☐ Relationship Issues	
☐ DTs/shakes	☐ GI bleeding	☐ Other _____	
☐ Increased tolerance	☐ Assaults		

Longest period of sobriety _____

Traded sex for drugs ☐ Yes ☐ No

Triggers to use _____

Risky behaviors	Addictive behaviors	Notes:
☐ Unprotected sex	☐ Sex	
☐ Gang involvement	☐ Gambling	
☐ Shoplifting	☐ Internet	
☐ Drug dealing	☐ Shopping	
☐ Reckless driving	☐ Video gaming	
☐ Carrying/using weapon	☐ Plastic surgery	
☐ Trespassing	☐ Thrill seeking	
☐ Fighting	☐ Food	

Risk Assessment:

Are you so distressed that you seriously wish to end their life	☐ Yes ☐ No
Is there a specific plan for how client would kill themself	☐ Yes ☐ No
Do you have access to weapons/means of hurting yourself.....	☐ Yes ☐ No
History of serious suicide attempt	☐ Yes ☐ No
Have you purposely done something to hurt themselves	☐ Yes ☐ No
Do you hear voices telling them to hurt themselves	☐ Yes ☐ No
Do you have relatives who attempted or committed suicide	☐ Yes ☐ No
Do you have thoughts of killing or seriously hurting someone...	☐ Yes ☐ No
Do you hear voices telling them to hurt others	☐ Yes ☐ No
Do you practice self-harm	☐ Yes ☐ No

Risk to self ☐ Low ☐ Medium ☐ High ☐ Chronic

Risk to others ☐ Low ☐ Medium ☐ High ☐ Chronic

Serious current risk of any of the following (immediate response needed)

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Abuse or family violence ☐ Yes ☐ No

Psychotic or severely psychologically disabled ☐ Yes ☐ No

Is there a gun in the home ☐ Yes ☐ No Plan ☐ Yes ☐ No

Any other weapons ☐ Yes ☐ No Reviewed Safety Plan ☐ Yes ☐ No

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Client Name: _____

Brief Mental Status Evaluation

Appearance
- ☐ Appropriate
- ☐ Inappropriate
- ☐ Disheveled
- ☐ Poor

Judgment
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Insights
- ☐ Full
- ☐ Partial
- ☐ Limited
- ☐ None

Speech
- ☐ Appropriate
- ☐ Slurred
- ☐ Rapid
- ☐ Pressured

Thought Content
- ☐ Hallucinations
- ☐ Delusions
- ☐ Paranoid
- ☐ Dissociation

Thought Process
- ☐ Irrelevant detail
- ☐ Disorganized
- ☐ Interrupted thinking
- ☐ Loose
- ☐ Illogical connections
- ☐ False beliefs

Mood
- ☐ Depressed
- ☐ Anxious
- ☐ Irritable
- ☐ Angry
- ☐ Elevated
- ☐ Euthymic

Behavior
- ☐ Appropriate
- ☐ Poor eye contact
- ☐ Distant/distracted
- ☐ Hostile
- ☐ Agitated
- ☐ Overly accommodating

Affect
- ☐ Expansive
- ☐ Euthymic
- ☐ Constricted
- ☐ Blunt
- ☐ Flat
- ☐ Dysphoric

Attitude to Examiner
- ☐ Seductive
- ☐ Playful
- ☐ Ingratiating
- ☐ Friendly
- ☐ Cooperative
- ☐ Interested
- ☐ Attentive
- ☐ Frank
- ☐ Indifferent
- ☐ Evasive
- ☐ Defensive
- ☐ Hostile

Intelligence
- ☐ Mild retardation
- ☐ Moderate retardation
- ☐ Severe retardation
- ☐ Profound retardation
- ☐ Dementia

Appropriateness
- ☐ Appropriate
- ☐ Inappropriate
- ☐ Labile

Notes:

Client Name: _____

Client Goals/Needs

Self-identified top three goals:

1. _____
2. _____
3. _____

Self-identified top three needs:

1. _____
2. _____
3. _____

What do you hope to gain from therapy:

What else do you want examiner to know:

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Client Name: _____

Diagnosis & Interpretive Summary

DSM-5 Diagnosis: Clinical Disorder(s)

Diagnostic Code	Disorder Name
Principal Diagnosis:	
Subtypes & Specifiers:	Severity:

Diagnostic Criterion:

A.	
B.	
C.	
D.	
E.	
F.	
G.	
H.	

DSM-5 Diagnosis: Clinical Disorder(s)

Diagnostic Code	Disorder Name
Secondary Diagnosis:	
Subtypes & Specifiers:	Severity:

Diagnostic Criterion:

A.	
B.	
C.	
D.	
E.	
F.	
G.	
H.	

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Client Name: _____

Diagnosis & Interpretive Summary - Cont.

Assessment Tools Used:

1. _____
2. _____
3. _____
4. _____
5. _____

Notes:

Treatment acceptance/resistance:

Client accepts problem ☐ Yes ☐ No

Client recognizes need for treatment ☐ Yes ☐ No

Client minimizes or blames other ☐ Yes ☐ No

Referrals:

☐ Psychiatrist	☐ Benefits coordinator	☐ Employment service
☐ Psychologist	☐ Nutritionist	☐ Social worker
☐ Medical provider	☐ Rehabilitation	☐ Community organization
☐ Spiritual counselor	☐ Vocational counselor	☐ Other _____

Brief summary:

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Client Name: _____

Diagnosis & Interpretive Summary - Cont.

Impressions:

Goals & recommendations:

_____ _____

Examiner's Signature Date