BIOPSYCHOSOCIAL ASSESSMENT

Demographics

Client name:	
Current address: Street City/State Zip Code	Phone: ( )
Date of birth:	Marital/relationship status:
Nation/tribe/ethnicity:	
Primary language:	
Referral source:	Referral source phone:
Emergency contact:	Emergency contact phone:

Family Relationships

Child's Name	Age	Sex	Custody: Y/N?	Lives with?	Additional Information

Who lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)			
Name	Age	relationship	Additional Information

Primary Language:	Other languages spoken:

Family History

Family history of (select all that apply):						
	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol/substance abuse	☐	☐	☐	☐	☐	☐
History of completed suicide	☐	☐	☐	☐	☐	☐
Mental health issues:						

Depression	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
Attention deficit/hyperactivity	☐	☐	☐	☐	☐	☐
Learning disorders	☐	☐	☐	☐	☐	☐
Behavior problems	☐	☐	☐	☐	☐	☐
Incarceration	☐	☐	☐	☐	☐	☐
Other (specify):						
Comments:						

Critical Populations (choose all that apply)

Funding Source	**Residential**	**Legal Involvement**
☐ Food stamp recipient	☐ Homeless	☐ DCFS
☐ TANF recipient	☐ Shelter resident	☐ Court ordered for services
☐ SSI recipient	☐ Long term care	☐ On probation
☐ SSDI recipient		☐ On parole
☐ Retirement income	Disability	**Other**
☐ Medicaid recipient	☐ Physical disability	☐ Pregnant
☐ Medicare recipient	☐ Severely/chronically mentally ill	☐ Woman with dependents
	☐ Developmentally disabled	

Client's presentation of the problem:
Client's expected outcome:

Physical Functioning

Allergies:
Current medical conditions:
Current medications (include over-the-counter):

Previous hospitalizations for medical issues:		
Dates	Location	Reason
Surgeries:		

Pain Questionnaire

Pain Management: Is the client in pain now? ☐ Yes ☐ No If yes, what is the client's self-reported level of pain on a scale of 1 – 10 (with 10 being the most severe)? Enter here: Is the client receiving care for this pain? ☐ Yes ☐ No Would the client like a referral for pain management? ☐ Yes ☐ No

Nutrition

Nutritional status: Current weight:	Current height:
Appetite: ☐ Good ☐ Fair ☐ Poor If poor, explain:	
☐ Recently gained/lost significant weight	☐ Binges/overeats to excess
☐ Restricts food/vomits/overexercises to avoid weight gain	☐ Special dietary needs Specify:
☐ Hiding/hording food	☐ Food allergies
Comments:	

Social

Supportive social network? (rate the network using a scale of 1-weak to 5-strong)	
Immediate family:	Extended family:
Friends:	School:
Work:	Religious:
Community:	Other:
Comments:	

Living Situation

☐ Housing adequate	☐ Housing dangerous	☐ Ward of state/tribal court	☐ Dependent on others
☐ Housing overcrowded	☐ Incarcerated	☐ Homeless	☐ At risk for homelessness
Additional information:			

Employment

Currently employed: ☐ Yes ☐ No If yes, type of work: ☐ full time ☐ part time
If yes: ☐ satisfied ☐ dissatisfied ☐ supervisor conflict ☐ coworker conflict
If no: Last time worked: Type of work: Reason for leaving:
Other: ☐ never employed ☐ disabled ☐ student ☐ unstable work history

Financial Stability

Presence or absence of financial difficulties: (check all that apply)
☐ no current problems ☐ large indebtedness ☐ financial difficulties ☐relationship conflicts over finances
☐ impulsive spending ☐ poverty or below poverty
Source of income: ☐ employed ☐ public assistance ☐ retirement ☐ medical disability/SSDI ☐ SSI ☐ other:

Military History

☐ never enlisted OR ☐ Branch of Service:
Combat: ☐ yes ☐ no
Type of discharge: ☐ honorable ☐ dishonorable ☐ medical ☐ other:

Sexual Orientation

☐ heterosexual ☐ bisexual ☐ homosexual ☐ transgendered ☐ N/A at this time
Comment:

Family/Social History

Describe family relationships and any desire for involvement in the treatment process: What is the client's perceived level of support from significant others for treatment? (on a scale of 1 – 5 with 5 being most supportive):

Legal Status Screening

Past or current legal problems? (select all that apply)
☐ None ☐ gang involvement ☐ DUI/DWI ☐ Arrests (describe):
☐ jail ☐ prison ☐ on probation ☐ on parole ☐ Other (explain):

Any history of or current court-ordered treatment: ☐ yes ☐ no		
Ordered by	**Offense**	**Length of Time**

Educational History

Educational level (select one): ☐ less than 12 years (enter last grade completed:) ☐ Some college/tech school
☐ unknown ☐ high school graduate/GED ☐ College graduate ☐Post-graduate degree
If still attending, what is current school and grade:
If college/graduate school, year completed and major:

Leisure and Recreation

Which of the following does the client engage in for leisure/recreation? (select all that apply)
☐ spend time with friends ☐ sports/exercise ☐ dancing ☐ hobbies ☐ watch movies/television
☐ stay at home ☐ spend time at clubs/bars ☐ take classes ☐ spend time with family ☐ listen to music
☐ travel ☐ go to casinos ☐ shopping ☐ other (describe):
Barriers to client's leisure/recreational activities:

Functional Assessment

Is client able to care for him/herself? ☐ yes ☐ no **If no please explain:**
Uses or needs assistive or adaptive devices? (select all that apply)
☐ none ☐ glasses ☐ hearing aids ☐ walker ☐ braille ☐ cane ☐ wheelchair
☐ translator for written information ☐ translator for speaking ☐ other (explain):

Psychological

History of depressed mood: ☐ yes ☐ no History of anxiety: ☐ yes ☐ no
History of manic or hypomanic episodes: ☐ yes ☐ no History of panic attacks: ☐ yes ☐ no
Sleep pattern: Number of hours per day: Amount of time it takes to fall asleep: ☐ normal ☐ excessive sleeping ☐ sleeping too little
Ability to concentrate: ☐ normal ☐ difficulty focusing/concentrating
Energy level: ☐ low ☐ average/normal ☐ high/excessive
History of / current symptoms related to posttraumatic stress disorder (re-experiencing, avoidance, increased arousal)? (select all that apply)

☐ intrusive memories, thoughts, perceptions ☐ nightmares ☐ flashbacks ☐numbing/detachment ☐ irritability ☐avoiding thoughts, feelings, conversations ☐restricted display of emotions ☐poor sleep ☐ hypervigilance ☐ Other:
Any additional information:

Bereavement

Please list significant losses, deaths, traumatic incidents involving loss:

Spiritual / Cultural Awareness & Practice

Practices traditions, spirituality, or religion? ☐ Yes ☐ No Comment:
How does the client describe his/her spirituality?
Does the client see a traditional healer? ☐ Yes ☐ No Comment:

Abuse / Neglect / Exploitation Assessment

History of neglect (emotional, nutritional, medical, educational) or exploitation? ☐Yes ☐ No If yes, please explain:
Has client been abused at any time in the past or present by family, significant others, or anyone else? ☐Yes ☐No If yes, please explain:

Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal putdowns			
Being threatened			
Made to feel afraid			
Pushed / shoved			
Slapped / punched / hit			
Kicked			
Strangled			
Forced or coerced into sexual activity			
Other:			

Was the abuse reported: ☐ Yes ☐ No If yes, to whom:
Outcome:

Has the client ever witnessed abuse or family violence: ☐Yes ☐ No If yes, explain:

Substance Use History

Drug	Age First Used	Age Heaviest Use	Most Recent Pattern of Use (include frequency and amount)	Date of Last Use
Alcohol				
Cannabis				
Cocaine				
Other Stimulants (amphetamines, methamphetamine, etc.) Specify:				
Inhalants (e.g. glue, paint, gas, etc.) Specify:				
Hallucinogens (e.g. LSD, PCP, psilocybin mushrooms, etc.) Specify:				
Opioids (e.g. heroin, methadone, etc.) Specify:				

Drug	Age First Used	Age Heaviest Use	Most Recent Pattern of Use (include frequency and amount)	Date of Last Use
Sedatives/Hypnotics (e.g. Valium, Phenobarbital, Xanax, etc.) Specify:				
MDMA				
Steroids				
Cough Syrup (DXM)				
Tobacco				

Has client ever injected drugs: ☐Yes ☐ No If yes, explain:

Drug of choice:

Consequences as a result of drug/alcohol use (select all that apply):

☐Hangovers ☐ DT/shakes ☐blackouts ☐binges ☐ overdoses ☐ increased tolerance ☐ GI bleeding ☐liver disease ☐ sleep problems ☐seizures ☐ relationship problems ☐problems at school ☐lost job ☐DUI ☐assaults ☐ involvement with judicial system ☐ homicide ☐ suicide attempts ☐communicable disease/s ☐Other (explain):

Longest period of sobriety: How long ago?:

List all triggers to use:

Has client experienced any of the following problem gambling behaviors? (select all that apply):

☐gambled longer than planned ☐gambled until last dollar was gone ☐ lost sleep due to thinking of gambling ☐ used income or savings to gamble while allowing bills to go unpaid ☐borrowed money to gamble ☐ made repeated, unsuccessful attempts to stop gambling ☐ been remorseful after gambling ☐ broken the law or considered breaking the law to finance gambling ☐ gambled to get money to meet financial obligations Other (explain):

Risk taking / impulsive behavior (current and past)—select all that apply:

☐unprotected sex ☐ reckless driving ☐gang involvement ☐selling drugs ☐carrying/using weapon ☐shoplifting Other (explain):

Mental Status Exam

General Observations

Appearance: ☐ well groomed ☐unkempt ☐disheveled ☐malodorous

Build: ☐ average ☐thin ☐ overweight ☐obese

Demeanor: ☐cooperative ☐ hostile ☐ guarded ☐ withdrawn ☐ preoccupied ☐ demanding ☐ seductive

Eye Contact: ☐ average ☐decreased ☐ increased

Speech: ☐clear ☐slurred ☐ rapid ☐ slow ☐ pressured ☐ soft ☐ loud ☐ monotone

Thought Content

Delusions: ☐ none reported/observed ☐grandiose ☐ persecutory ☐somatic ☐ bizarre ☐religious ☐nihilist

Other: ☐phobias ☐excessive/unwarranted guilt ☐ anhedonia ☐thought broadcasting ☐thought insertion ☐obsessions ☐compulsions ☐ ideas of reference

Self-Abuse

☐none reported/observed ☐self-mutilation ☐ history of suicide attempt/s ☐suicidal thoughts

Is client currently at risk for suicide (explain):

Perception

Hallucinations: ☐ none reported ☐ auditory ☐ visual ☐ olfactory ☐gustatory ☐ tactile

Describe:

Thought Process

☐logical ☐goal oriented ☐circumstantial ☐ tangential ☐ loose ☐ rapid thoughts ☐incoherent ☐concreate ☐ blocked ☐flight of ideas ☐ perseverative ☐ derailment

Describe:

Mood:

☐ stable ☐ euthymic ☐ depressed ☐anxious ☐angry ☐ euphoric ☐irritable

Affect:

☐appropriate (congruent with mood) ☐flat ☐ inappropriate ☐ labile ☐ blunted

Behavior:

☐ no behavior issues ☐assaultive ☐resistant ☐aggressive ☐agitated ☐hyperactive ☐restless ☐ sleepy ☐intrusive

Movement:

☐ akasthisia ☐dystonia ☐ tardive dyskinesia ☐tics

Cognition:

Impairment of: ☐orientation ☐memory ☐attention/concentration ☐ ability to abstract

Describe:

☐no impairment reported or observed

Impulse Control:

☐good ☐poor ☐absent Describe:

Insight:

☐good ☐poor ☐ absent Describe:

Judgment:

☐good ☐poor ☐ absent Describe:

Risk Assessment

Risk to self: ☐ low ☐medium ☐ high ☐ chronic Explain:

Risk to others: ☐ low ☐ medium ☐ high ☐ chronic Explain:

Serious current risk of any of the following:

Abuse or family violence? ☐yes ☐no Psychosis? ☐yes ☐no Are there guns in the home? ☐ yes ☐no

Is a safety plan needed? ☐ yes ☐no Why or why not?

Diagnoses and Interpretive Summary

Narrative Summary: (provide detailed summary written in narrative form of information gathered from the client for assessment)

DSM 5 Diagnosis (include all diagnoses; substance use disorders should be listed first; include numeric code from DSM 5 and level of severity)

Treatment Acceptance / Resistance

Client accepts problem? ☐ yes ☐ no Explain:
Client recognizes need for treatment? ☐ yes ☐ no Explain:
Client minimizes or blames others? ☐ yes ☐ no Explain:
External motivation for treatment? ☐ yes ☐ no Explain:

Strengths / Resources

Enter score if present: **1 = adequate 2=above average 3 = exceptional**
Family support:____ Social support: ____ relationship stability: _____ intellectual/cognitive skills:_____
Resiliency: _____ socio-economic stability_____ communication skills _____ parenting skills: _____
maturity and judgment skills:_____ motivation for help:_____
Other (explain):

Family/Significant Other's Participation in Treatment

Will client's family/significant others be involved in treatment? Describe appropriateness and level of need for family's/SO's participation:

Preliminary Treatment Plan & Referrals

Briefly identify problems/goals to be addressed on treatment plan in various areas below:

Biological:

Psychological:

Social:

Environmental:

Identify referrals needed to meet client's needs:

☐psychiatrist ☐ medical provider ☐ spiritual counselor ☐ nutritionist ☐ vocational counselor
☐eating disorder specialist ☐ domestic violence counseling ☐ housing ☐ financial counseling
☐food pantry ☐ assistance in applying for benefits Other (specify):