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Adult Biopsychosocial Assessment

General Information

Date: _____ DOB: _____ Age: _____

Full Name: _____

Name you prefer to be called: _____

Address: _____

Mailing address if different from above:
_____

Race: White ____ Black ____ American Indian/Alaskan Native ____ Asian ____
Native Hawaiian/Pacific Islander ____ Multi Racial ____

Ethnicity: Puerto Rican ___ Mexican ___ Cuban ___ Hispanic ___ Haitian ___
Other _____

Marital Status: Never Married ____ Married ____ Widowed ____ Divorced ____
Separated ____

Emergency Contact:

Name: _____ Relationship: _____
Home Number: _____ Work Number: _____
Cell Number: _____

Party responsible for paying the bill:

Client _____ Other: _____ (If other complete below)
Name: _____ Relationship: _____
Home Number: _____ Work Number: _____
Cell Number: _____ SS#_____
Address:_____

I am seeking help for:

___ Depression
___ Anxiety
___ Relationship problems
___ Homelessness
___ Domestic violence/abuse
___ Not sure
___ Drug problem
___ Alcohol problem
___ Legal problems
___ Gambling problem
___ Job problems
___ School problems

Other: _____

History of Presenting Problem:

_____
_____
_____
_____
_____

I was referred here by:

___ Physician or psychiatrist
___ Friend or relative
___ Clergy
___ No one
___ DCF (Dept. of Children and Families)
___ Judge/Court/Legal
___ Probation/Parole Officer
___ Other: _____

In the past year my income has:

___ Not changed
___ Increased
___ Decreased

During the last month, how many days of work or school have you missed?

___ 0 days
___ 1-3 days
___ 4-6 days
___ 7-9 days
___ 10 or more days
___ Not working or in school

Your goals for therapy:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Relationships and Family

Who lives or stays with you?

Name	Relationship	Part-time	Full-Time

I am currently married or in a significant relationship:
___ Yes ___ No

If yes, this relationship is:
___ Good ___ Fair ___ Poor

My current relationship with my friends is:
___ Good ___ Fair ___ Poor

I receive some emotional support from my family and/or friends:
___ Yes ___ No
If yes, is it enough?
___ Yes ___ No
Other source of emotional support:
_____

Overall my childhood was:
___ Good ___ Fair ___ Poor

As a child, my relationship with my mother was:
___ Good ___ Fair ___ Poor

As a child, my relationship with my father was:
___ Good ___ Fair ___ Poor

As a child, my relationships with my friends were:
___ Good ___ Fair ___ Poor

As a child, my relationships with other family members were:
___ Good ___ Fair ___ Poor

A significant friend or relative of mine has died in the last year:
___ Yes ___ No
If yes, who? _____ Cause of death: _____

Please give the name, age, and sex of each of your children:

For each child:	Name	Name	Name	Name	Name
Age					
Sex					

My status as a parent is: (Please check the appropriate box)

Biological parent					
Step parent					
Foster parent					
Adoptive parent					
Other					

Religion and Culture

What are the religious, spiritual, cultural, or ethnic considerations that I should be aware of as I meet with you?

_____
_____
_____
_____
_____

Education

Are you currently enrolled in school/college/training? ___ Yes ___ No

If yes, ___ Full-time ___ Part-time

The highest grade you completed in school was: _____

Was your school experience: ___ Good ___ Fair ___ Poor

Do you want to go back to school or training? ___ Yes ___ No

List degrees, licenses, special training, etc.

_____
_____
_____
_____
_____

Employment

Current Employment:
___ Full-time
___ Part-time
___ Unemployed
___ Volunteer work

Name of Employer _____
Describe the work you do:

_____
_____
Length of Service: _____
Relationship with co-workers: ___ Good ___ Fair ___ Poor
Relationship with Supervisor: ___ Good ___ Fair ___ Poor

Military

Have you served in the military? ___ Yes ___ No
What branch of service? _____
Were you in combat? ___ Yes ___ No
If applicable, please describe your combat service:

_____
_____
_____
_____

Legal

Have you ever been arrested? ___ Yes ___ No
If yes, how many times? _____
If yes, please give details:

_____
_____
_____
_____

Are you currently on probation? ___ Yes ___ No
Are you currently on parole? ___ Yes ___ No
Are you currently in drug court? ___ Yes ___ No
Are you currently in domestic violence court? ___ Yes ___ No

Alcohol and Other Drugs

Do members of your family currently use alcohol or other drugs? ___ Yes ___ No
If yes, who? _____

Do members of your family have a history of using alcohol or drugs?
___ Yes ___ No
If yes, who? _____

At any time in the last 30 days, have you felt that you should reduce or stop:
Smoking cigarettes ___ Yes ___ No ___ Do not use
Smoking marijuana ___ Yes ___ No ___ Do not use
Using alcohol ___ Yes ___ No ___ Do not use
Using drugs ___ Yes ___ No ___ Do not use
Has drinking or taking drugs caused you any problems with school, work, friends, spouse, police, or your health:
Currently ___ Yes ___ No
Within the last year ___ Yes ___ No
Please explain:
_____
_____
_____
Did alcohol or drugs cause problems for you at one point in your life, but are not a problem now?
___ Yes ___ No ___ Never used/drank

Has anyone else expressed concern about your drinking or drug use?
___ Yes ___ No ___ Never used/drank
If yes, who? _____

Does your personality change under the influence of alcohol or drugs?
___ Yes ___ No ___ Never used/drank

Have you ever blacked out when drinking?
___ Yes ___ No ___ Never used/drank

Have you ever attended AA? ___ Yes ___ No How long? _____
Have you ever attended NA? ___ Yes ___ No How long? _____

What is the longest time your were clean and sober? _____

Please check the appropriate boxes and fill in the appropriate blanks.

Type of Drug	**Never**	**Last 6 months**	**Last 48 hours**	**Age first used**	**Most used in one day over last 6 months**
Alcohol					
Amphetamines: • Speed • Uppers • Crystal • Meth • Crank Pills ___ Smoke ___					
Cannabis • Marijuana • Pot • Hashish					
Cocaine/Crack • Blow • Rock • Coke • Freebase Powdered ___ Freebase ___					
Hallucinogens • LSD • Ecstasy • MDA • DMT • Mescaline • Mushrooms					
Inhalants • Glue • Gasoline • Paint thinner • Spray can propellant					

Type of Drug	**Never**	**Last 6 months**	**Last 48 hours**	**Age First used**	**Most used in one day over last 6 months**
Opioids • Heroin • Demerol • Codeine • Morphine • Fentanyl • China white • Methadone Phencyclidine & Similar • PCP • Ketamine • "K"					
Sedatives, Hypnotics & Anxiolytics • Barbituates • "Downers" • Benzodiazepines • Xanax • Valium • "Roofies"					
Other • Darvocet • Steroids • GHB • Amyl nitrite • "Poppers" • "Rush" • Painkillers					
Nicotine • Cigarettes • Cigars • Chewing tobacco • Dip					

Medications

Current Medication

Medication Name	Date Prescribed	Dosage & Frequency	Doctor	Side Effects	Taken as Prescribed?
					__ Yes __ No
					__ Yes __ No
					__ Yes __ No
					__ Yes __ No
					__ Yes __ No
					__ Yes __ No

Previous Medications (last 2 years)

Medication Name	Date Prescribed	Dosage & Frequency	Doctor	Side Effects	Taken as Prescribed?
					__ Yes __ No
					__ Yes __ No
					__ Yes __ No
					__ Yes __ No
					__ Yes __ No
					__ Yes __ No

Medical

Please describe any significant diseases, surgeries, or injuries from your past or present:

_____
_____
_____

Do you have any known allergies, including medication allergies?
___ Yes ___ No
If yes, please describe:

_____
_____
_____

Primary Doctor and Phone Number:

_____

Psychiatrist and Phone Number:

_____

Mental Health

Have any members of your family had: (Check all that apply)
___ Depression
___ Anxiety
___ Mental illness If so, what mental illness? _____
___ Job problems
___ School problems
___ Drug/alcoholism problems
___ Legal problems
___ Gambling problems
___ Other _____

Have you previously been to a counselor or psychiatrist?
___ Yes ___ No

During the last 6 months, have you thought of seriously hurting yourself or other people?
___ Yes ___ No

Have you ever attempted suicide?
___ Yes ___ No If so, how many times? _____

Do you currently have plans to harm yourself?
___ Yes ___ No If yes, how would you plan to do it? _____

During the last month, how often have you been getting out of the house to do what you usually do during the day?
___ Never ___ Seldom ___ Often ___ Very frequently

During the last month, how often have you been getting out of the house to do thing you enjoy?
___ Never ___ Seldom ___ Often ___ Very frequently

Are you concerned about sexual issues, past or present?
___ Yes ___ No If yes, please explain:
_____
_____
_____

Have there been times in the past when your appetite changed significantly?
___ Yes ___ No

Your weight the last 6 months:
___ Maintained the same weight
___ Gained _____ pounds
___ Lost _____ pounds

Appetite during the last month:
___ Normal ___ Eating more than normal ___ Poor

Have you had sleep problems in the past?
___ Yes ___ No

Have there been times when you didn't need much sleep?
___ Yes ___ No

Your usual sleep pattern is: (Check all that apply)
___ Normal sleep
___ Problem falling asleep
___ Problems staying asleep
___ Nightmares
___ Irregular sleep
___ Sleep too much

Violence and Trauma

Were you ever a victim of a violent crime?
___ Yes ___ No Age_____

Were you ever raped?
___ Yes ___ No Age_____

When you were a child, were you ever touched or fondled in a sexual way that made you feel uncomfortable, or were you made to touch/fondle someone in a sexual way?
___ Yes ___ No Age_____
If yes, did this happen more than once?
___ Yes ___ No

Were you ever forced to have sex by your spouse/significant other?
___ Yes ___ No

Has anyone stalked you, in other words, followed you or kept track of your activities, causing you to feel intimidated or concerned for your safety?
___ Yes ___ No
If yes, please describe:
_____
_____
_____

Are you currently afraid of someone harming you in?
___ Yes ___ No
If yes, please explain:
_____
_____
_____

If you answered yes to any of the above questions about violence and sexual trauma, do you currently experience any of the following?

Flashbacks	___ Yes	___ No
Nightmares	___ Yes	___ No
Insomnia	___ Yes	___ No
Fearfulness	___ Yes	___ No
Numbness	___ Yes	___ No
Other	___ Yes	___ No

If other, please explain:
_____
_____

Strengths & Abilities

What of the following will help you in therapy? (Check all that apply and list others you think will help.)

___ Support from family (parents, children, others)
___ Support from spouse or significant other
___ Support from friends
___ Connection to self-help group (AA, NA, etc.)
___ A positive and supportive sponsor
___ Connection to a church group or minister
___ Counselor or case manager
___ Psychiatrist
___ Judge or probation officer
___ Employer
___ Financial security, assistance or benefits
___ Permanent residence
___ I am very motivated about treatment.
___ I am able to make an appropriate transition to living in a recovering community.
___ I have good interpersonal skills.
___ I have good emotion-management skills.
___ I have good reasoning and analytical skills.
___ I have am able to recognize my problems.
___ I have good self-esteem.

___ I have some positive plans and goals for my future.
___ I am willing to do whatever it takes to be more functional and peaceful.
___ I have a good relationship with a Higher Power.
___ I have areas of my life in which I take pleasure.
___ I have good work skills and work experience.
___ I have an education.
___ Other:
_____
_____
_____
_____

Needs

What do you want to derive from therapy? (Check all that apply and list others you think of that are not shown.)

___ More thorough understanding of my problems
___ Improvement in my interpersonal skills/relationships
___ Improvement in my communication skills
___ Contact with supportive people
___ Emotion management skills
___ Anger management skills
___ Personal safety plan
___ Parenting skills
___ Obtaining and keeping a job
___ Education regarding my health
___ Relapse prevention
___ Coping skills
___ Referral to a mental health facility
___ Referral to a psychiatrist
___ Other:
_____
_____
_____
_____