

## **BIOPSYCHOSOCIAL ASSESSMENT – ADULT**

Today's Date	Name						
Date of Birth	of Birth Email Address						
Preferred Language Do you ne				ed an Interpreter? Yes    No			
Please complete this form in	its entirety. If you wish not	to disclose personal inf	ormation, please check	"No Ansv	ver" (N	A).	
PRESENTING PROBLEM	l						
Please describe what	brings you in today?						
	een experiencing this pro				□5+ ye	ears	
	the problem 1 to 5 (1 beir						
	nterfering with your day-t it goals for therapy? If tre						
6. Are you currently or i	in the last 30 days experie	enced any of the follo	owing symptoms? (ch	eck all th	at app	oly)	
□ Sadness	□Hopeless/Helpless	□ Sleep Too Much	□ Fatigue/No Energy	□ Poo	□ Poor Memory		
□ No Motivation	□ Lack of Interest	<ul><li>□ Thoughts of Dying</li></ul>	□ Guilt		□ Feel Worthless		
□ Not Hungry	□ Prefer Being Alone	□ Irritable/ Angry	□ Can't Sleep	□ Too Much Energy			
□ No Need for Sleep	□ Talk Too Fast	□ Impulsive	□ Can't Concentrate		□ Restless/Can't Sit Still		
□ Suspicious	☐ Hearing Things	□ Seeing Things	<ul><li>□ Have Special Powers</li></ul>		□ People Watching Me		
□ People Out to Get Me	☐ Feeling Nervous	□ Fearful	□ Panic Attacks	□ Can't be in Crowds			
□ Easily Startled	□ Avoidance	<ul><li>□ Re-occurring Nightmares</li></ul>		Yes	No	NA	
7. Do you now or have you ever contemplated suicide?							
8. Are you a survivor of trauma?  9. Are you pregnant now?				8. 🗆			
	due? (day/month/year)			9. □			
11.Are you at risk for HI	//AIDS/Sexually Transmitt	ted Diseases (unsafe	sex, using needles?)	11. 🗆			
12. Please list allergies to	o medications or food:						
13. Has your physical hea	alth kept you from partici			13. 🗆			
For staff use only:							
Client Name:		Client Nun	nber:				

TOBACCO		`	'es	No	NA
1. Have you ever used any forms of tobacco (cigarettes, snuff, etc.)? <b>IF NO SKIP TO NEXT</b>					
2. Are you a former tobacco user?					
3. If yes, what form(s) of tobacco have you used in the past ( <i>please check all that appl</i>		۷.	Ш		Ш
□ Cigarettes □ Cigars □ Snuff □ Chewing Tobacco □ Snuff □ Other	,				
4. How many times on an average day do you use tobacco (1-99)?					
Cigarettes Cigars Snuff Chewing Tobacco Snuff					
5. Have you been involved in a program to help you quit using tobacco in the past 30		5.			
days?					
6. If so, which self-help group was used?					
SUBSTANCE LIST /ADDICTION DESCENT		,	/oc	No	NΙΛ
SUBSTANCE USE/ADDICTION PRESENT  1. Would you are someone you know source having a problem with placehold.			'es	No	NA
Would you or someone you know say you are having a problem with alcohol?      Would you or someone you know say you are having problems with nills or illegal.					
Would you or someone you know say you are having problems with pills or illegal drugs?					
Would you or someone you know say you are having problems with other addiction			П		
gambling, pornography or shopping?					
4. Have you ever been to a self-help group?					
SUBSTANCE USE/ADDICTION PAST			'es	No	NA
1. Would you or someone you know say you had a problem with alcohol?					
2. Would you or someone you know say you had problems with pills or illegal drugs?		2.			
3. Would you or someone you know say you had problems with other addictions, ie.					
gambling, pornography or shopping?					
4. Is there a family history of addiction in your family?					
5. If yes, please describe:					
DEDCOMAL FAMILY AND DELATIONICHIDS		,	/	Na	NIA
PERSONAL, FAMILY AND RELATIONSHIPS  1. Who is in your family? (parents, brothers, sisters, children, etc.)		ן	'es	No	NA
1. Wilo is in your family: (parents, brothers, sisters, children, etc.)					
2. Has there been any significant person or family member enter or leave your life in t	he	2.			
last 90 days?					
Good Fair Poor Clos	se St	ressfu	Dis	tant C	Other
3. How are the relationships in your family?	]				
4. How are the relationships in your support system (friends,	]				
extended family, et.?)	Δhu	ise Str	224	loss (	Other
5. Are there any problems in your family now? (check all that apply)   6. Were there any problems with your family in the past? (check all that					
apply)		_			
7. Are there any problems in your support system now? (check all that			]		
apply)					
8. Were there any problems with your support system in the past? (check $\ \ \Box$			]		
all that apply)					
9. What is your marital status now? □Single □Married □Living as Married □Divorced					
□Widowed □Never Married					
For staff use only:					
Client Name: Client Number:					

	Yes	No	NA
10. Have you ever had problems with marriage/relationships?	10. □		
11. If yes, please check why: □Stress □Conflict □Loss □Divorced/Separation □Trust Issues □Other			
12. Do you have any close friends?	12. □		
13. Do you have problems with friendships?	13. □		
14. Do you get along well with others (neighbors, co-workers, etc.)?	14. □		
15. What do you like to do for fun?			
EDUCATION	Yes	No	NA
1. What is the highest grad you completed in school? (please check)  □No Education □K-5 □6-8 □9-12 □GED □College Degree □Masters Degree			
2. Would you describe your school experience as positive or negative?  ———————————————————————————————————			
3. Are you currently in school or a training program?	3. □		
LEGAL	Yes	No	NA
1. Have you ever been arrested? IF NO SKIP TO NEXT SECTION	1. 🗆		
2. In the past month?			
3. If yes, how many times?	<b>≟.</b> ⊔	Ц	
4. In the past year?	4. □		
5. If yes, how many times?			
6. If yes, what were you arrested for?			
7. What was the name of your attorney?			
8. Were you ever sentenced for a crime?	8. □		
9. If yes, number of prison sentences served?			
10. What year(s) did this occur?			
<ul><li>11. Are you currently or have you ever been on probation or parole?</li><li>12. If yes, what is the name of your attorney or probation officer?</li></ul>	11. □		
WORK	Yes	No	NA
What is your work history like? □Good □Poor □Sporadic □Other	103		147 (
2. How long do you normally keep a job? □Weeks □Months □Years			
3. Are you retired?	3. □		
4. If yes, what kind of work do you do/did you do in the past?			
5. Have you ever served in the military?	5. □		
6. If yes, are you: □Active □Retired □Other			
MEDICAL			
1. Current Primary Care Physician:Phone			
2. Past and Current Medical/Surgical Problems:		_	
3. Past and Current Medications and Dosages:		_	
4. Have you seen a Mental Health Professional Before? ☐ Yes ☐ No			
5. If yes, Name, When, and Reason for Changing:			
6. Current Psychiatrist/APRN, if applicable:			
7. Is there anything else you would like me to know about you?		_	
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