



# BIOPSYCHOSOCIAL ASSESSMENT – ADULT

Today's Date _____	Name _____
Date of Birth _____	Email Address _____
Preferred Language _____	Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete this form in its entirety. If you wish not to disclose personal information, please check "No Answer" (NA).

## PRESENTING PROBLEM

1. Please describe what brings you in today? \_\_\_\_\_
2. How long have you been experiencing this problem?  Less than 30 day  1-6 months  1-5 years  5+ years
3. Rate the intensity of the problem 1 to 5 (1 being mild and 5 being severe):  1  2  3  4  5
4. How is the problem interfering with your day-to-day functioning? \_\_\_\_\_
5. What are your current goals for therapy? If treatment were to be successful, what would be different?  
\_\_\_\_\_  
\_\_\_\_\_

6. Are you currently or in the last 30 days experienced any of the following symptoms? (*check all that apply*)

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Sadness              | <input type="checkbox"/> Hopeless/Helpless  | <input type="checkbox"/> Sleep Too Much          | <input type="checkbox"/> Fatigue/No Energy   | <input type="checkbox"/> Poor Memory              |
| <input type="checkbox"/> No Motivation        | <input type="checkbox"/> Lack of Interest   | <input type="checkbox"/> Thoughts of Dying       | <input type="checkbox"/> Guilt               | <input type="checkbox"/> Feel Worthless           |
| <input type="checkbox"/> Not Hungry           | <input type="checkbox"/> Prefer Being Alone | <input type="checkbox"/> Irritable/Angry         | <input type="checkbox"/> Can't Sleep         | <input type="checkbox"/> Too Much Energy          |
| <input type="checkbox"/> No Need for Sleep    | <input type="checkbox"/> Talk Too Fast      | <input type="checkbox"/> Impulsive               | <input type="checkbox"/> Can't Concentrate   | <input type="checkbox"/> Restless/Can't Sit Still |
| <input type="checkbox"/> Suspicious           | <input type="checkbox"/> Hearing Things     | <input type="checkbox"/> Seeing Things           | <input type="checkbox"/> Have Special Powers | <input type="checkbox"/> People Watching Me       |
| <input type="checkbox"/> People Out to Get Me | <input type="checkbox"/> Feeling Nervous    | <input type="checkbox"/> Fearful                 | <input type="checkbox"/> Panic Attacks       | <input type="checkbox"/> Can't be in Crowds       |
| <input type="checkbox"/> Easily Startled      | <input type="checkbox"/> Avoidance          | <input type="checkbox"/> Re-occurring Nightmares |  |   |

- |   |  |
|---|--|
| 7. Do you now or have you ever contemplated suicide?.....                                   | 7. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA  |
| 8. Are you a survivor of trauma?.....   | 8. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA  |
| 9. Are you pregnant now?.....   | 9. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA  |
| 10. If yes, when are you due? (day/month/year) _____  |  |
| 11. Are you at risk for HIV/AIDS/Sexually Transmitted Diseases (unsafe sex, using needles?) | 11. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |
| 12. Please list allergies to medications or food: _____                                     |  |
| 13. Has your physical health kept you from participating in activities?.....                | 13. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |

### For staff use only:

Client Name: \_\_\_\_\_ Client Number: \_\_\_\_\_



- |  | Yes                          | No                       | NA                       |
|--|------------------------------|--------------------------|--------------------------|
| 10. Have you ever had problems with marriage/relationships?.....   | 10. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. If yes, please check why: <input type="checkbox"/> Stress <input type="checkbox"/> Conflict <input type="checkbox"/> Loss <input type="checkbox"/> Divorced/Separation<br><input type="checkbox"/> Trust Issues <input type="checkbox"/> Other _____ |                              |                          |                          |
| 12. Do you have any close friends?.....  | 12. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have problems with friendships?.....  | 13. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you get along well with others (neighbors, co-workers, etc.)?.....  | 14. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)<br><input type="checkbox"/> No Education <input type="checkbox"/> K-5 <input type="checkbox"/> 6-8 <input type="checkbox"/> 9-12 <input type="checkbox"/> GED <input type="checkbox"/> College Degree <input type="checkbox"/> Masters Degree |                             |                          |                          |
| 2. Would you describe your school experience as positive or negative? _____   |                             |                          |                          |
| 3. Are you currently in school or a training program?.....  | 3. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**LEGAL**

- |   | Yes                          | No                       | NA                       |
|---|------------------------------|--------------------------|--------------------------|
| 1. Have you ever been arrested? <b>IF NO SKIP TO NEXT SECTION</b> .....   | 1. <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. In the past month?.....  | 2. <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If yes, how many times? _____  |                              |                          |                          |
| 4. In the past year?.....   | 4. <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. If yes, number of prison sentences served? _____                       |                              |                          |                          |
| 10. What year(s) did this occur? _____                                    |                              |                          |                          |
| 11. Are you currently or have you ever been on probation or parole?.....  | 11. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. If yes, what is the name of your attorney or probation officer? _____ |                              |                          |                          |

**WORK**

- |   | Yes                         | No                       | NA                       |
|---|-----------------------------|--------------------------|--------------------------|
| 1. What is your work history like? <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Sporadic <input type="checkbox"/> Other |                             |                          |                          |
| 2. How long do you normally keep a job? <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years                           |                             |                          |                          |
| 3. Are you retired?.....  | 3. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. If yes, are you: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Other   |                             |                          |                          |

**MEDICAL**

- Current Primary Care Physician: \_\_\_\_\_ Phone \_\_\_\_\_
- Past and Current Medical/Surgical Problems: \_\_\_\_\_
- Past and Current Medications and Dosages: \_\_\_\_\_
- Have you seen a Mental Health Professional Before?  Yes  No
- If yes, Name, When, and Reason for Changing: \_\_\_\_\_
- Current Psychiatrist/APRN, if applicable: \_\_\_\_\_
- Is there anything else you would like me to know about you? \_\_\_\_\_

**For staff use only:**

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