Adult Biopsychosocial Assessment

Personal Information

Name: _____DOB: _____ Age: _____ M / F_____

Address:_____ City:_____ St:_____ Zip:_____

Insurance Company: _____ Policy #: _____ CoPay $_____

Name of Insured: _____ Insured DOB: _____ Relation to Patient: _____

Presenting Crisis Situation

Presenting Problem: Why are you seeking counseling *now*? What's going on now? If there are major life issues which are currently impacting you at this time (*pregnancy, recent or pending incarceration, probation, a terminal illness, parental divorce, death of a parent or sib or other close relationship*)

_____

_____

_____

_____

_____

Medical

Primary Care Provider: _____Phone: _____

Medical history and current medical symptoms or issues: _____

_____

_____

Medication:

Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

Name Dose Schedule Physician

1._____

2._____

3._____

Recent medication change? ☐ Yes ☐ No Date_____ Describe change: _____

Medication history: Over the counter meds? Vitamins? Supplements? _____

Allergies (including food) or adverse side effects to medications: Describe: _____

Behavioral Symptoms:

Sleep disturbance (increased/decreased, hours per night, DFA, MNA, restlessness, nightmares)

_____

Appetite problems

_____

Loss of energy, concentration, motivation, etc.

_____

Excessive guilt / Self-blame

_____

Irritability

_____

Isolating / withdrawing from family or friends

_____

Feelings of helplessness or hopelessness

_____

Does the client have difficulties caring for self? (Deteriorating hygiene or grooming)

_____

Chronic worry / fear / uncertainty (If "Yes" describe below with frequency and reason for worry)

_____

Panic attacks (If "Yes" describe below)

_____

Last panic attack _____

Obsessive thoughts / compulsive behaviors (If "Yes" describe below)

_____

Specific fears (social phobia / agoraphobia / simple phobias)

_____

Severe mood fluctuations

_____

Anger outbursts / tantrums / reactions disproportionate to stressor

_____

Frequent crying spells for no apparent reason

_____

Manic or hypo-manic symptoms (racing thoughts, decreased sleep, spending splurges, difficulty concentrating)

_____

Abuse-Addiction-Behavioral

	Age first used	Pattern of Use: when, how much, where…	Date last used
Alcohol			
Cannabis			
Cocaine			
Stimulants (crystal, speed, amphetamines, etc.)			
Benzodiazepines – Ativan, Xanax			
Inhalants (paint, glue, gas, etc.)			
Hallucinogens (LSD, PCP, Mushrooms)			
Opioids (heroin, pain pills, narcotics, methadone) IV?			
Designer drugs, (herbal, steroids, cough syrup, anything else)			
Tobacco (Smoke, chew)			
Caffeine			
Longest period of sobriety?			
Problems w/ SA: Hangovers: OD's: Binges: Blackouts: Relationship: Medical: Legal: School: Employment::			
Gambling or other addictions?			

If you are in Recovery, what is your plan?

_____

_____

Socio-economic history

Who primarily raised you most of your life? Were your parents married? Divorced/Separated? Any step-parents?

What number child are you? _____ child of _____ children born to mom and dad. How many brothers and sisters do you have?

Full Brothers: _____ age/dob_____ Half-brothers: _____ age/dob_____ Stepbrothers: _____ age/dob_____

Full Sisters: _____ age/dob_____ Half-sisters: _____ age/dob_____ Stepsisters: _____ age/dob_____

What was it like growing up in your family? Needs met? Did you go without? Were you worried about stuff as a kid?

_____

_____

_____

Any history of abuse or any trauma as a child?

_____

_____

Physical/Sexual Abuse_____

Other _____

Did you witness any abuse_____

Exposed to trauma _____

Any domestic violence issues or substance abuse issues with parents/step-parents? How has that affected you?

_____

_____

_____

Current Living Situation

Are you married, living with someone, single, separated, divorced, widowed _____ For how long_____

How many times have you been married (or serious long-term relationships)? _____

#1_____

#2_____

#3_____

Describe relationship with spouse / partner. Does he/she think there's any serious problems in the relationship?

_____

_____

Are/were there any domestic violence issues or any substance abuse issues with spouse/partner?

_____

_____

Do you have any children/step-children? Ages_____

Any Child Protective Service involvement with your kids?_____

Describe your relationship with your children or step-children?_____

_____

_____

Who lives in household now? Any changes expected? (*Birth of a baby, separation/divorce, family members moving in/out*)

_____

_____

_____

Are you dealing with any grief issues? _____

_____

_____

Legal history *(Arrests, incarcerations)*

_____

_____

_____

Education / Profession / Training

_____
_____
_____

Employment

_____
_____
_____

Spiritual/Religious:

Are you active in religious activities? _____Any specific denomination? _____

Describe your spirituality: _____
Do you believe your spirituality can help you with your problem?_____
_____

Financial Problems that are affecting your life or relationships?

_____
_____

Suicide Risk

Have you ever thought about hurting yourself? Have you ever cut / hurt yourself deliberately?

Have you ever thought of suicide? □ Yes □ No _____

Have you ever attempted suicide □ Yes □ No _____

_____
_____

Thinking about it currently? □ Yes □ No Plan: _____ Means_____ Intent: _____

Access to a weapon? _____

Has anyone in your family or a close friend ever attempted or committed suicide? _____
_____
_____

Homicide Risk:

Have you ever thought of hurting or threatened or attempted to hurt others? □ Yes □ No_____

Have you ever actually physically hurt anyone? □ Yes □ No _____

_____

Psychosis - current or history

Hallucinations

___ Yes ___ No Auditory _____
___ Yes ___ No Visual _____
___ Yes ___ No Tactile _____
___ Yes ___ No Olfactory _____

Delusions

___ Yes ___ No Delusions of persecution or paranoia _____
___ Yes ___ No Delusions of reference _____
___ Yes ___ No Delusions of grandeur_____
___ Yes ___ No Delusions of control_____

Comments:

_____
_____
_____

Mental Status Exam

- Appearance: □ WNL □unkempt □poor hygiene □ tense □ rigid
- Behavior/Motor Disturbances: □ WNL □agitated □guarded □tremor □manic □impulsive □psychomotor retardation □ tearful □easily startled □distracted □hysterical □ restless
- Orientation: □ WNL □ Disoriented to: □time □place □person □situation
- Speech: □ WNL □ pressured □ slowed □soft □loud □slurred □ incoherent
- Mood: □ WNL □depressed □angry □hostile □euphoric □anxious □anhedonic □withdrawn
- Range of Affect: □ WNL □constricted □blunted □flat □labile □inappropriate
- Thought Content: □ WNL □impaired □unfocused □unreasonable □preoccupation □delusions □thought insertion□ grandiose □ideas of reference □paranoid □obsessions □phobias
- Thought Process: □ WNL □ illogical □abstract □concrete □incoherent □ perseverative □impaired concentration□ loose associations □ flight of ideas □circumstantial □blocking □tangential
- Sensory: □ WNL □ illusions □ flashbacks □ hallucinations: □auditory □visual □olfactory □ tactile
- Memory: □ WNL □ Impaired: □ recent □ remote □ immediate
- Appetite: □ WNL □ increased □decreased Weight: □ stable □ loss □ gain
- Sleep: □ WNL □ hypersomnia □onset problem □ maintenance problem
- Insight: □ WNL □ blaming □little □ none
- Judgment: □ WNL □ impaired □ poor
- Estimated Intellectual Functioning: □above average □ average □below average □diagnosed mr □unable to determine

Mental Status Summary

_____

_____

Diagnosis: _____

Recommendations

This client may benefit from behavioral outpatient therapy to address:

_____

_____

Counselor Signature with Credentials: _____ Date/Time completed: _____