Heart & Family Health Institute
Behavioral Health
(772) 398-7936

# Biopsychosocial Assessment

**Date of Appointment:________/______/______________** **Time:__________AM / PM**

**Name:______________________________________** **DOB:____/______/______** **Age:_________**

**Relationship/ Marital status:______________________**

## Presenting Problem

1. Please describe what brings you in today?____________________________________________________________________________________________________________________________________________________________________________________________________

2. How long have you been experiencing this problem?
□ less than 30 days □1-6 months □ 1-5 years □ 5+ years

**How Severe on a scale of 1-10, do you rate your presenting problems?**

Least Severe 1 2 3 4 5 6 7 8 9 10 Most Severe

## Presenting Problem Symptoms

□ sadness □ hopeless/helpless □ sleep too much □ fatigue/no energy □ poor memory
□ no motivation □ lack of interest □ thoughts of dying □ 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 □ have special powers □ people watching me
□ people out to get me □ feeling nervous □ fearful □ panic attacks □ can't be in crowds
□ easily startled □ avoidance □ re-occurring nightmares □ depression □ mood swings
□ decreased appetite □ increased appetite □ anxiety

**Trauma** (please circle):

Physical abuse Sexual abuse Elder abuse Adult molested as a child

Robbery victim Assault victim Dating violence Domestic Violence

Human trafficking DUI/DWI Crash Survivors of homicide victim PTSD

Other:__________________________________________________________________________________________________________________

**How do you rate your current level of coping on a scale of 1 – 10?**

UNABLE TO COPE 1 2 3 4 5 6 7 8 9 10 ABLE TO COPE

**Psychiatric/ Psychological History**

**Have you received mental health services in the past** □ Yes □ No
If yes, whom did you see and when?____________________________________________________________

**Are you presently seeing a Therapist/ Psychiatrist?** □ Yes □ No
*If yes, please give name, phone number, length of treatment* ________________________________________

**Have you had any voluntary or involuntary admissions to a psychiatric facility/ hospital?** □ Yes □ No
*If yes, please list all prior inpatient or outpatient treatments.*

| Year | Reason | Hospital/ Facility |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please answer if you have any of the listed problems now or in the past:**

| | Past | Present | Both | Never |
|---|---|---|---|---|
| Fire Setting | □ | □ | □ | □ |
| Animal Cruelty | □ | □ | □ | □ |
| Running Away | □ | □ | □ | □ |
| Lying/ Cheating | □ | □ | □ | □ |
| Stealing/ Robbing | □ | □ | □ | □ |
| Destroying Property | □ | □ | □ | □ |
| Fighting/ Aggression | □ | □ | □ | □ |
| Selling Drugs | □ | □ | □ | □ |
| Learning problems | □ | □ | □ | □ |
| Hyperactivity/ Inattentiveness | □ | □ | □ | □ |
| Distractibility | □ | □ | □ | □ |
| Conflict with peers | □ | □ | □ | □ |
| Conflict with family | □ | □ | □ | □ |
| Binging/ Purging/ Restricting | □ | □ | □ | □ |
| Gambling | □ | □ | □ | □ |
| Compulsive sexual behavior | □ | □ | □ | □ |

**Medications in relation to mental health**

***List your prescribed drugs for mental health issues*** *(including psychotropic, over-the-counter, herbal remedies)*
***☐ not taking***

| Name of Drug | Dosage | Reason for medication | Frequency | Prescribed by | Date Began | Last Day Taken |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

***Are you taking medications as prescribed?*** ***□ Yes □ No***

***Allergies to medications***

| Name of Drug | Reaction You Had |
|---|---|
| | |
| | |
| | |
| | |

**Pain:**

**Do you have any pain presently, if so identify the pain on a scale from 0 to 10 with 0 being no pain and 10 being the worst:**______________________________

**Have you ever been treated for pain?** □ Yes □ No

**Prescribed medication:**______________________________

**When?**______________ **Who Prescribed pain medication?**______________________________

**Chemical & Behavioral**

| Drug | N/A | Age First Used | Age Heaviest Use | Recent Pattern of Use (frequency & Amount, ) | Date Last Used |
|---|---|---|---|---|---|
| Alcohol | ☐ | | | | |
| Cannabis/ marijuana | ☐ | | | | |
| Cocaine | ☐ | | | | |
| Stimulants (crystal, speed, amphetamines, etc) | ☐ | | | | |
| Methamphetamine | ☐ | | | | |
| Inhalants (gas, paint, glue, etc) | ☐ | | | | |
| Hallucinogens (LSD, PCP, mushrooms, etc) | ☐ | | | | |
| Opioids (heroin, narcotics, methadone, etc) | ☐ | | | | |
| Sedative/Hypnotics (Valium, Phenobarbital, etc) | ☐ | | | | |
| Designer Drugs/Other (herbal, Steroids, cough syrup, etc) | ☐ | | | | |
| Tobacco (smoke, chew) | ☐ | | | | |
| Caffeine | ☐ | | | | |

**Ever injected Drugs?** ☐ Yes ☐ No **If Yes, Which ones?**

**Drug of Choice?**

**Consequences as a Result of Drug/Alcohol Use (select all that apply)**

| | | | |
|---|---|---|---|
| ☐ Hangover | ☐ DTs/Shakes | ☐ Blackouts | ☐ Binges |
| ☐ Overdose | ☐ Increased Tolerance (need more to get high) | ☐ GI Bleeding | ☐ Liver Disease |
| ☐ Sleep Problems | ☐ Seizures | ☐ Relationship Problems | ☐ Left School |
| ☐ Lost Job | ☐ DUIs | ☐ Assaults | ☐ Arrests |
| ☐ Incarcerations | ☐ Homicide | ☐ Other: | |

**Longest Period of Sobriety?** **How long ago?**

**Any legal involvement?** ☐ Yes ☐No
**Explain:**

**If legal involvement, did you receive probation?** ☐ Yes ☐ No
**Are you currently on probation?** ☐ Yes ☐ No
**Probation officer name:**

**Triggers to use (list all that apply):**

**Has client traded sex for drugs?** ☐ No ☐ Yes, explain:

**Has client had any of the following problem gambling behaviors?** Select all that apply:

| | |
|---|---|
| ☐ Gambled longer than planned | ☐ Gambled until last dollar was gone |
| ☐ Lost sleep thinking of gambling | ☐ Used income or savings to gamble while letting bills 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 |
| ☐ Other: | ☐ Gambled to get money to meet financial obligations |

**Risk Taking/Impulsive Behavior (current/past) – select all that apply:**

| | | |
|---|---|---|
| ☐ Unprotected sex | ☐ Shoplifting | ☐ Reckless driving |
| ☐ Gang Involvement | ☐ Drug Dealing | ☐ Carrying/using weapon |
| ☐ Other: | | |

## History of Abuse/Neglect

***Have you ever been abused or assaulted? ☐ Yes ☐ No***

***Do you feel like you are in danger now?☐ Yes ☐ No***

| **Type of Abuse** | **By whom?** | **What Age?** | **Was it reported?** | **Did you receive treatment? If so, when?** |
|---|---|---|---|---|
| ☐ Sexual | | | | |
| ☐Physical | | | | |
| ☐Emotional | | | | |
| ☐Verbal | | | | |
| ☐Abandoned/Neglected | | | | |

## History of Violence

*Have you ever been accused of abusing or assaulting someone? ☐ Yes ☐ No*

| **Type of Abuse** | **To whom?** | **What age?** | **Was it reported?** | **Did you receive treatment? If so, when?** |
|---|---|---|---|---|
| ☐ Sexual | | | | |
| ☐Physical | | | | |
| ☐Emotional | | | | |
| ☐Verbal | | | | |
| ☐Abandoned/Neglected | | | | |

## Nutrition

*In the last 90 days have you lost or gained 10lbs or more? ☐ Yes ☐ No*

**Appetite:** ☐ Good ☐ Fair ☐ Poor

| | | | |
|---|---|---|---|
| ☐ Recently gained/ lost significant | ☐ Binge/ overeat | ☐ Restrict food/over-exercise to avoid weight gain | ☐ Special dietary need |
| ☐ Hiding/hoarding food | ☐ Food allergies | ☐ Vomiting (self-induced) | ☐ Night Eating |

**Comments:**

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## Family Composition

*(Please list the names, ages, relationships, and other relevant information regarding all immediate family members whether living in or outside the home, please include all members currently residing in YOUR household)*

| Name | Gender | Age | Relationship To Patient | Living with Patient |
|---|---|---|---|---|
| | | | | □Yes □No |
| | | | | □Yes □No |
| | | | | □Yes □No |
| | | | | □Yes □No |
| | | | | □Yes □No |
| | | | | □Yes □No |
| | | | | □Yes □No |

**Recent Loss/Bereavement:**

□ Family Member □ Friend □ Health □ Income □ Housing □ Relationship □N/A

Who/What?________________________________________________________

____________________________________________________________

When?__________________________________ Nature of Loss?____________________

Other Losses:______________________________________________________

____________________________________________________________

## Family Mental Health History

**Has your Mother, Father, Sister or Brother, or any other relative been diagnosed with any of the following?**

| | Mother | Father | Sister | Brother | Other Relative: (specify) |
|---|---|---|---|---|---|
| Depression | □ | □ | □ | □ | □: |
| Anxiety | □ | □ | □ | □ | □: |
| Bipolar Disorder | □ | □ | □ | □ | □: |
| Schizophrenia | □ | □ | □ | □ | □: |
| ADHD / ADD | □ | □ | □ | □ | □: |
| Trauma History | □ | □ | □ | □ | □: |
| Abusive Behavior | □ | □ | □ | □ | □: |
| Alcohol Abuse | □ | □ | □ | □ | □: |
| Drug Abuse | □ | □ | □ | □ | □: |
| Other | □ | □ | □ | □ | □: |

**Are you adopted?**

☐ Yes ☐ No

## Strengths/Resources/Supports

**What do you do well?**____________________

**What resources do you have to help with your current problem?**____________________

**What experiences do you have to help with your current problem?**____________________

**What are you (and your family) already doing to improve the current situation?**____________________

**Would you consider your household stable? Why or why not.**____________________

**What else do you believe is important to understand about your living situation?**____________________

**Who can you count on for support?** *(Can be one person, a group, a facility, etc.)*____________________

## Current Needs/Goals

**What do you feel is your biggest need right now?**____________________

**What do you most hope to gain from Therapy?**____________________

**If you were to pick three goals to work on, what would they be?**
**1.**____________________
**2.**____________________
**3.**____________________

**What else would you like for us to be aware of?**____________________

**Who can we contact to help us with your treatment?**
**Family (or non-family) Contact Name:**____________________ **Relationship:**____________________
**Phone number:**____________________
**Patient's family presentation of problem(s) and expected outcomes:**____________________

**Patient Name** (Printed)**:**______________________________________________

**Signature of patient or patient representative:**______________________________

**Date:**______________

**Relationship to patient:**______________________________________________

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***For Office Staff Only***

**Person reviewing information:**__________________________________________

**Signature:**_________________________________________________________

**Date:**__________________________ **Time:**____________________

◄——————————**DO NOT CONTINUE**——————————►