Client Name: _____Date: _____

T.W. PONESSA & ASSOCIATES COUNSELING SERVICES, INC.

Corporate Office: 410 N. Prince Street Lancaster, PA 17603
(717) 560-7917 Fax (717) 560-6452

BRIEF BIOPSYCHOSOCIAL

1. What is your current address: _____
   _____
   _____
   Phone number: _____

2. Have there been any changes to your living arrangement in the last year? (Example moved, new family member, etc.) Yes / No
   _____
   _____

3. Do you want to make any changes to your Emergency Contact or Primary Care Provider? Yes / No
   _____
   _____

4. Would you like therapy at this time? Yes / No
   If no, are you receiving therapy elsewhere? Yes / No
   _____
   _____

5. Relationship Status: Single /Married /Widowed /Divorced /Separated
   Is this a change in the last year? Yes / No
   _____
   _____

6. Have you suffered any losses or a traumatic event? (Example abuse, accident, job loss, death, violence, etc.) Yes / No
   _____
   _____

7. What issues/concerns/stresses are you currently dealing with?
   _____
   _____

8. Have you ever had thoughts of wanting to kill yourself or others? Yes / No
   _____
   _____

9. Are you dealing with any medical conditions, allergies or other medical concerns? Yes / No
   _____
   _____

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10. CHIEF COMPLAINTS: Place a check mark next to all symptoms below that help explain the problems that you/client are experiencing at the present time.

- □ Abuse (Physical/Sexual/Emotional)
- □ Aggressive or violent behavior
- □ Anger issues
- □ Bladder or bowel control problems
- □ Complaints about school behavior
- □ Criminal behavior/Involved with probation or parole
- □ Cruelty/Harm to animals
- □ Depression, Sadness or feeling down
- □ Developmental Delays (Delays in learning, growth, speech, social)
- □ Drug Use/Alcohol Use
- □ Easily Distracted
- □ Eating problems (Not eating enough/Overeating)
- □ Fatigue/Feeling tired/Lack of energy
- □ Fear of "going crazy"
- □ Fear of losing control
- □ Feeling disconnected from your body
- □ Flashbacks
- □ Gambling
- □ Hopelessness
- □ Housebound (Does not want to leave the house)
- □ Hyperactivity (Full of energy all day long)
- □ Identity issues (Confusion about who you are or want to be)
- □ Impulsive behavior (Does not think before acting)
- □ Irritability (Often acts miserable and complains a lot)
- □ Loss of a loved one, Loss of a relationship, Grief Issues
- □ Lying
- □ Mood swings
- □ Nervousness (Worrying)
- □ Nightmares
- □ Numerous physical complaints (Complains about feeling sick)
- □ Obsessive thoughts (Cannot stop thinking about something no matter how much you try)
- □ Panic Attacks/Anxiety
- □ Paranoia (Extreme fear or distrust of others)
- □ Poor grades
- □ Poor hygiene/Self-care (Problems with bathing and keeping body clean)
- □ Problems concentrating
- □ Problems getting along with others/making and keeping friends
- □ Problems remembering things
- □ Racing thoughts
- □ Recent trauma (Please specify): _____
- □ Relationship (Marriage/Significant other) or family conflict
- □ Seeing or hearing things that other people cannot see/hear
- □ Self-harm such as cutting/burning self
- □ Setting fires
- □ Severe or chronic pain
- □ Sexual Issues
- □ Sleep problems (Increased or decreased need to sleep)
- □ Stealing
- □ Tobacco use
- □ Other_____

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11. Do you feel that the medications prescribed by your psychiatrist are working for you? Yes / No

    _____
    _____

12. Where do you attend school (if applicable)? What grade are you currently in?

    _____
    _____

13. Where do you currently work (if applicable)? Are you experiencing any stress related to your job? Yes / No

    _____
    _____

14. Do you have any current or pending legal charges? Yes / No
    Misdemeanor / Felony _____
    _____

15. Do you have any substance use/abuse concerns? Yes / No

    _____
    _____

16. Do you have any change in your military status? Yes / No

    _____
    _____

17. Do you have a WRAP (Wellness Recovery Action Plan) or Mental Health Advance Directive? Yes / No

    _____
    _____

18. What are some things about you that you would like us to know (such as likes, dislikes, how you spend your free time, hobbies, etc.)?

    _____
    _____

19. What are your strengths (what you are good at, your positive characteristics, etc.)?

    _____
    _____

20. Who are your supports (family, friends, community activities/agencies, church etc.)?

    _____
    _____

_____
Client Signature Date

_____
Therapist Signature Date