Consumer's Name_____

BIOPSYCHOSOCIAL HISTORY & ASSESSMENT

(Consumers- Age 18-years-old and older)

*Please complete to the best of your ability the information below regarding you or the person you are seeking services for.

SECTION 1: GENERAL INFORMATION:

Name of person who is completing this form: _____ Relationship to Consumer: _____

Consumer's Name:_____ Today's Date:_____

Address:_____
City:_____ State:_____ Zip Code:_____
How long has the consumer lived at this address:_____ Phone Number: _____
Email Address: _____
Consumer's D.O.B.:_____ Gender: Male / Female / Transgender / Non-Binary / Other: _____
Preferred Pronoun: He / She / They / Other: _____
Consumer's SS#:_____

Who should be contacted if there is an emergency?

Emergency Contact's Name_____

Address_____

Phone Number_____

Relationship to Consumer_____

Who referred consumer for services?: □ Family member □ Friend □ Doctor □ Insurance Company □ Phone Book □ Internet □ Other _____

Presenting Problem/Recent Stressor(s) - What are the main reason(s) that you are seeking services for yourself/consumer at this time?

_____
_____
_____

SECTION 2: CHIEF COMPLAINTS:

Place a checkmark next to all symptoms below that help explain the problems that you/consumer 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

Consumer's Name_____

- ☐ 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/Anxiety)
- ☐ Nightmares
- ☐ Numerous physical complaints (Complains about feeling sick)
- ☐ Obsessive thoughts (Cannot stop thinking about something no matter how much you try not to)
- ☐ Panic Attacks
- ☐ 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_____

SECTION 3: PSYCHIATRIC/MENTAL HEALTH ASSESSMENT:

1. Are you (or the consumer) currently receiving mental health treatment with this agency or through another agency? ☐ Yes ☐ No
   If yes, please explain what other services you are currently receiving.
   _____
   _____

2. Have you (or the consumer) ever had counseling services before? ☐ Yes ☐ No
   If yes, please list where and when.
   _____
   _____

3. Have you (or the consumer) ever been hospitalized for mental health problems before? ☐ Yes ☐ No
   If yes, please list where and when.
   _____
   _____

4. Have you (or the consumer) ever been diagnosed with a mental health condition? ☐ Yes ☐ No

Consumer's Name_____

If yes, please list the diagnosis/diagnoses and who made the diagnosis/diagnoses.

5. Have you (or the consumer) ever spent time in a residential treatment facility or another long term treatment facility? ☐ Yes ☐ No If yes, please list where and the dates that you were in treatment.

6. Have you (or the consumer) ever had thoughts that you wanted to harm or kill yourself? ☐ Yes ☐ No
If yes, are these thoughts that you have had recently? If yes to either question, please explain:

7. Have you (or the consumer) ever had thoughts that you wanted to harm or threaten someone else? ☐ Yes ☐ No
If yes, are these thoughts that you have had recently? If yes to either question, please explain:

8. Have you (or the consumer) ever cut, burned or injured yourself in a way that was not an accident? ☐ Yes ☐ No
If yes, please explain and note if is this a current concern:

SECTION 4: BRIEF FAMILY HISTORY:

1. Do you (or the consumer) have any family members who suffer from mental health problems? ☐ Yes ☐ No
If yes, please explain:

2. Do you (or the consumer) have any family members who suffer from drug and/or alcohol problems? ☐ Yes ☐ No
If yes, please explain:

3. Do you (or the consumer) have any family members who have committed suicide? ☐ Yes ☐ No
If yes, please explain:

4. Are there any concerns regarding family members (either living or deceased) that may be impacting you (or the consumer) at the present time? ☐ Yes ☐ No If yes, please explain.

SECTION 5: MEDICAL SCREENING: PERSONAL AND FAMILY MEDICAL HISTORY:

1. Have you (or the consumer) been diagnosed with any medical conditions? ☐ Yes ☐ No

Consumer's Name_____

If yes, please list all current medical conditions.

_____

_____

2. On average, how many hours of sleep do you (or the consumer) get per day/night?
   - ☐ Less than 6 hours
   - ☐ 6 - 8 hours
   - ☐ More than 8 hours

3. Do you (or the consumer) take any medication(s)? ☐ Yes ☐ No
   If yes, please list the current medication name(s), dosage, how often you take the medication, who is prescribing the medication, and what you are taking the medication for.

   _____

   _____

   _____

4. Do you (or the consumer) have any allergies that you know of? ☐ Yes ☐ No If yes, please list.

   _____

   _____

SECTION 6: ADDICTION HISTORY:

1. When was the last date you (or the consumer) drank alcohol? What did you drink and how much did you drink?

   _____

   _____

2. What do you usually drink, how much do you drink and how frequently are you/were you (or the consumer) drinking alcohol?

   _____

   _____

3. How old were you (or the consumer) when you first started drinking alcohol?

   _____

   _____

4. Have you (or the consumer) ever used drugs? If yes, list what specific drugs and how much do you use?

   _____

   _____

5. When was the last date you (or the consumer) used drugs? What did you use and how much did you use?

   _____

   _____

6. How frequently are you/were you (or the consumer) using drugs?

   _____

   _____

7. How old were you (or the consumer) when you first started using drugs?

   _____

   _____

8. Is there any other behavior that you believe you do in excess or are concerned about? ☐ Yes ☐ No
If yes, please explain.

_____

_____

9. Have any of the above behaviors listed in questions 1-8 impacted your (or the consumer's) relationships with family and friends? ☐ Yes ☐ No If yes, please explain:

_____

_____

10. Have any of the above behaviors listed in questions 1-8 impacted your (or the consumer's) ability to perform your responsibilities at work, home and/or school? ☐ Yes ☐ No If yes, please explain.

_____

_____

SECTION 7: TRAUMA HISTORY:

1. Have you (or the consumer) ever been physically, sexually, emotionally, verbally abused or neglected as a child?
☐ Yes ☐ No If yes, please explain.

_____

_____

2. Have you (or the consumer) ever physically, sexually, emotionally, verbally abused or neglected a child(ren)?
☐ Yes ☐ No If yes, please explain.

_____

_____

3. Have you (or the consumer) ever been charged with physically, sexually, emotionally, verbally abusing, neglecting or assaulting others? ☐ Yes ☐ No If yes, please explain.

_____

_____

4. Are you now or have you (or the consumer) ever been in a relationship where you were physically, sexually, emotionally or verbally abused? ☐ Yes ☐ No If yes, please explain.

_____

_____

5. Have you (or the consumer) ever witnessed physical, sexual, emotional or verbal abuse? ☐ Yes ☐ No
If yes, please explain.

_____

_____

6. Have you (or the consumer) ever witnessed or experienced domestic violence or any other type of violence?
☐ Yes ☐ No If yes, please explain.

_____

_____

7. Have you (or the consumer) ever witnessed or experienced any other type of traumatic event? ☐ Yes ☐ No
If yes, please explain.

_____

_____

Consumer's Name_____

SECTION 8: LEGAL ASSESSMENT:

1. Have you (or the consumer) ever been charged with a summary offense, misdemeanor, felony, etc.?
☐ Yes ☐ No If yes, please explain.

_____

_____

2. Do you (or the consumer) have any pending charges? ☐ Yes ☐ No If yes, please explain.

_____

_____

3. Are you (or the consumer) currently on probation/parole? ☐ Yes ☐ No If yes, please explain.

_____

_____

SECTION 9: FAMILY ASSESSMENT:

1. What City/State were you (or the consumer) born and raised?

_____

2. Who raised you (or the consumer)? (Biological parents/Grandparents/Foster Care, etc.)

_____

3. Do you (or the consumer) have any brothers/sisters? If yes, please list names and ages.

_____

_____

4. Do you (or the consumer) have any children? If yes, please list names, ages and where they reside.

_____

_____

_____

5. What is your (or the consumer's) current relationship status?
Please Circle: Married Single Divorced Separated Widowed

SECTION 10: LIVING SITUATION:

1. Who do you (or the consumer) live with currently? Please list ALL household members, their relationship to you (or the consumer) and how well you get along.

_____

_____

_____

_____

2. Have you (or the consumer) had multiple changes in living situations throughout your life? ☐ Yes ☐ No
If yes, please explain.

_____

_____

3. Have you (or the consumer) ever lived with someone who was suffering from a mental illness? ☐ Yes ☐ No

Consumer's Name_____

If yes, please explain.

_____

_____

4. Have you (or the consumer) ever lived with someone who has a drug/alcohol problem? ☐ Yes ☐ No
   If yes, please explain.

   _____

   _____

5. Have you (or the consumer) ever been homeless? ☐ Yes ☐ No If yes, please explain.

   _____

SECTION 11: PERSONAL ASSESSMENT:

Leisure Activity:

1. What are you (or the consumer) good at? What do other people tell you that you are good at?

   _____

   _____

2. What do you think your (or the consumer's) strengths are? What do other people tell you that your strengths are?

   _____

   _____

Sexuality and Gender: (Please complete if you feel comfortable)

1. What is your (or the consumer's) identified gender?
   Please Cirble: Male Female Transgender Non-Binary Other

2. How do you (or the consumer) identify your sexual orientation?
   Please Circle: Heterosexual Homosexual Bi-Sexual Asexual

SECTION 12: VOCATIONAL/EDUCATIONAL HISTORY:

1. What is the highest level of schooling you (or the consumer) have completed?
   Please Circle: High School Diploma/GED Associate's Bachelor's Master's Other

2. Are you (or the consumer) currently working? ☐ Yes ☐ No
   If yes, please explain what you do and if you are working part-time or full-time.

   _____

   _____

I verify all information is truthful to the best of my knowledge (please sign below):

_____

Consumer's Signature Date

STAFF USE ONLY

I verify I reviewed the above information:

_____

Staff Signature Date

Printed Name of Clinician Reviewing this form_____

_____

Staff Signature Date

Printed Name of Clinician Reviewing this form_____