Biopsychosocial Assessment

Demographics

Date: 04/28/2015 **Admit Date:** **Time Begun:** 8:16am **Time Ended:**

Presenting Problem:

Client Name: John Doe **Patient ID#:** 1

Address: ,

Telephone (Home): **Cell:**

Date of Birth: **Age:** **Sex:**

Email:

Social Security #:

General Information

Do you receive any type of disability insurance (SSI, SSDI, Medicaid, Medicare)? ○ No ◉ Yes

If Yes, what type:

Number:

What is your primary language?

Do you have trouble with either reading or writing English? ○ No ◉ Yes

If Yes, please describe:

If Yes, will this have any affect on your ability to receive counseling? ○ No ◉ Yes

If Yes, please explain:

Do you use any assistive devices (i.e.: wheelchair, walking devices, etc.) ○ No ◉ Yes

☐ **Ambulatory**

☐ **Assistive Devices**

☐ **Wheelchair** ☐ **Crutches** ☐ **Cane** ☐ **Prosthetics**

☐ **Other**

Other equipment BLANK

Do you have reliable transportation? ○ No ◉ Yes

Explain:

Do you have a valid driver's license? ○ No ◉ Yes

Emergency Contact Information

In case of an emergency, contact - Name:

Name of Primary Care Physician (PCP):

Telephone # of PCP:

Address of PCP:

Descriptive Information

Height: **Weight:**

Eye Color: **Hair Color:**

Ethnicity:

Any identifying physical characteristics (scars, tattoos):

Have you been in a controlled environment in the last 30 days: ○ No ◉ Yes

If Yes, please explain:

Substance Abuse History

Substance	Current Usage Past 30 Days	If yes, pattern of use last 30 days (include amount and frequency)	Age of 1st Use	Age this became a problem?	Pattern of use for at least last 6 months (include amount and frequency)	Primary Route:(Oral, IV, etc.)	Date, Time, and amount of last use
Alcohol	○ No ◉ Yes						
Amphetamines	○ No ○ Yes						
Barbiturates	○ No ○ Yes						
Benzodiazepines	○ No ○ Yes						
Xanax	○ No ○ Yes						
Valium	○ No ○ Yes						
Klonopin	○ No ○ Yes						
Cocaine	○ No ○ Yes						
Hallucinogens	○ No ○ Yes						
Inhalants	○ No ○ Yes						
Marijuana	○ No ○ Yes						
Methamphetamine	○ No ○ Yes						
Opioids	○ No ○ Yes						
Hydrocodone	○ No ○ Yes						
Oxycodone	○ No ○ Yes						
Morphine	○ No ○ Yes						
Methadone	○ No ○ Yes						
Heroin	○ No ○ Yes						
Oxycontin	○ No ○ Yes						
Other opioid	○ No ○ Yes						
Bath Salts	○ No ○ Yes						

Chemical Dependence Treatment History

Have you ever been treated for a substance abuse issue? ○ No ◉ Yes

If yes, list treatment below:

Location	Dates of Treatment	Level of Care	Length of Stay	Length of Sobriety	Outcome: If relapsed, why?

Key:

Level 1: OUTPATIENT SERVICES (including traditional outpatient treatment or ambulatory detox without extended on-site monitoring.)

Level 2: INTENSIVE OUTPATIENT / PARTIAL HOSPITALIZATION SERVICES (including ambulatory detox with extensive on-site monitoring)

Level 3: RESIDENTIAL / INPATIENT SERVICES

Level 4: MEDICALLY MANAGED INTENSIVE INPATIENT SERVICES

Client Directed Outcome Informed Screen

What are your expectations/outcomes from this treatment?

What specific problems do you want to address while in treatment?

Client's self reported:

Strengths:

Needs:

Abilities:

Treatment Preferences:

Client's self reported problems and challenges:

Client's self reported interests and activities:

Has there been any change in these interests and activities as a result of substance use: ○ No ◉ Yes

If Yes, describe:

List other people that you would like to be involved in your treatment and their relationship to you:

Confidential Releases of Information signed? ◉ No ○ Yes

Emotional/Behavioral

Have you ever been given a psychiatric diagnosis? ○ No ◉ Yes

If Yes, diagnosis

Who made the diagnosis: **When?**

Have you received mental health services or are you currently receiving services? ○ No ◉ Yes

If Yes, list treatment below:

Location	Date of Treatment	Level of Care	Duration of Treatment	Diagnosis or Reason in Treatment

Other details

If Yes, please explain:

Are you concerned you may have an eating disorder? ○ No ◉ Yes

Have you ever been treated for an eating disorder? ○ No ◉ Yes

If Yes, please give name, location and type of treatment facility, date(s) attended, length attended, reason attended and outcomes/responses to treatment:

If Yes, please explain:

Are you concerned you may have a gambling issue? ○ No ◉ Yes

Have you ever been treated for a gambling issue? ○ No ◉ Yes

If Yes, please give name, location and type of treatment facility, date(s) attended, length attended, reason attended and outcomes/responses to treatment:

If Yes, please explain:

Are you concerned you may have sexual compulsivity? ○ No ◉ Yes

Have you ever been treated for sexual compulsivity? ○ No ◉ Yes

If Yes, please give name, location and type of treatment facility, date(s) attended, length attended, reason attended and outcomes/responses to treatment:

If Yes, please explain:

Are you concerned you may have trauma issues: ○ No ◉ Yes

Have you ever been treated for traumatic issues: ○ No ◉ Yes

If Yes, please give name, location and type of treatment facility, date(s) attended, length attended, reason attended and outcomes/responses to treatment:

Are you interested in treatment for your mental health issues? ○ No ◉ Yes

Post-Admission Safety Assessment

Section I: Suicide Screening

Current suicidal thoughts? ○ No ○ Yes, Passive ◉ Yes, Active

If Yes, what is the plan, intent or means to accomplish

Section II: Self-Harm Screening

None (skip to next section) ○ None ◉ Self-mutilation

If "Self-mutilation" is selected, describe in detail; when, where on body, with what, required medical intervention? For how long, date of most recent.

Section III: Aggression Screening

☐ **None (skip to next section)** ☐ **Verbal** ☐ **Physical**

Individual Risk Features (Describe in detail all factors specific to this individual that could place them at risk for self-harm (i.e., history of suicide attempts, family history of suicide, high risk behaviors with no regard to personal safety, etc.)

Environmental Risk Features (Describe in detail all factors specific to the individual's environment that could place them at risk for self-harm (i.e., access to weapons, drugs/prescribed medications, lack of family/social supports, isolation, etc.)

Section IV: Risk Category

Risk Category (See Key): ○ No safety risk ○ Mild safety risk ○ Moderate safety risk ○ High safety risk

Key:
NO SAFETY RISK:
1. Routine Monitoring; 2. No thoughts; 3. No plan; 4. No notification; 5. Safety environment

MILD SAFETY RISK:
1. Routine monitoring; 2. Discuss mild risk status with clinical team; 3. Some thought; 4. No plan; 5. Notify therapist

MODERATE SAFETY RISK:
1. Implement increased supervision; 2. Discuss moderate risk status with clinical team; 3. Some thought; 4. No plan; 5. Notify therapist; 6. Develop Personal Safety Plan (add to Tx Plan)

HIGH SAFETY RISK:
1. Line of sight supervision (use LOS doc. sheet); 2. Psychiatric consult; 3. Re-evaluation of risk at each session; 4. Develop Personal Safety Plan (add to Tx Plan)

Section V: Individualized Action Plan (Individualized Action Plan should include the following):

Client Risk Category (see key): ○ Moderate risk ○ High risk

Key:
MODERATE RISK:
1. Increased supervision; 2. Clinical team consultation; 3. Periodic re-evaluation; 4. Personal Safety Plan

HIGH RISK:
1. Line of Sight supervision; 2. Psychiatric consultation; 3. Re-evaluation of risk at each session; 4. Personal Safety Plan

Family History

Number of children?

Please list name, age, current residence and health of each sibling:

Name	Age	Gender	Current residence	Health

Is there any current or past family history of substance related disorders? ○ No ◉ Yes

If Yes, please describe:

Is there any current or past family history of mental illness? ◉ No ○ Yes

Please list any pertinent medical history in the client's family:

Raised by: ○ Parents ○ One Parent ○ Relatives ○ Foster ○ Adoptive

Describe your childhood:

If No, please explain:

As a child, did you feel that all your physical and emotional needs were met by your parents or caregivers? ◉ No ○ Yes

Describe your past and current relationships with parents/siblings/others (important bonds, strained relationships, losses, etc):

List or describe how your substance abuse or another family member's substance abuse has affected your family:

Residence: ○ Own ○ Rent ○ Living w/family ○ Living w/friends ○ Group/Boarding Home ○ Shelter ○ No stable residence ○ Homeless

Lives with?

Is your current living environment safe? ○ No ◉ Yes

What has been your usual living arrangement for the past three years?

Were you or any other family member emotionally, physically or sexually abused? ○ No ◉ Yes

If Yes, please list the relationship of the abused, abuser and type of abuse:

Would you like counseling for these issues? ○ No ◉ Yes

Are you experiencing any family problems? ○ No ◉ Yes

If Yes, please explain:

Are you interested in counseling for family problems? ○ No ◉ Yes

Is your living environment supportive? ○ No ◉ Yes

Explain:

Can you return there or do you need placement? ○ Return Home ○ Need Placement ○ Uncertain

Explain as needed:

Will your family or significant other participate in your treatment? ○ No ◉ Yes

Explain

What is your family / significant other's expectation of your treatment?

Interview with family / significant other (if applicable):

With whom do you spend most of your free time and how?

Do you have a recovery support network in place? ○ No ◉ Yes

Please describe:

Are you experiencing any social problems? ○ No ◉ Yes

If Yes, please explain:

Are you interested in counseling for social problems? ○ No ◉ Yes

Relationship / Marital History

Current marital status:

How many times have you been married? (Include length of time and status for each marriage)

Has any relationship dissolved due to alcohol / drug problems? ○ No ◉ Yes

If Yes, please explain:

If currently married or in a relationship, name and age of partner:

Is partner living with you? ○ No ◉ Yes

If Yes, please describe:

Are you satisfied with your current relationship? ○ No ◉ Yes

Other than client, does anyone in the home abuse alcohol/drugs? ○ No ◉ Yes

If Yes, who?

Does anyone in the home have any other addiction problems (i.e, gambling, pornography, eating, Internet, etc)? ○ No ◉ Yes

If Yes, please explain:

Are you experiencing or have you experienced any domestic violence issues? ○ No ◉ Yes

If Yes, please explain:

Any children? ○ No ◉ Yes

If Yes, ages:

If Yes, who will care for them in your absence:

Are there any current or past problems with your children? ○ No ◉ Yes

If Yes, please describe:

Are you interested in family or couples counseling? ○ No ◉ Yes

School/Education

What is the highest level of education completed?

Currently attending school? ◉ No ○ Yes

Name of current school:

If you did not graduate, explain

Training or technical education completed?

Are you interested in furthering your education? ○ No ◉ Yes

Has the client received any medical or educational treatment for learning disabilities? ○ No ◉ Yes

Any behavioral issues, physical limitations (such as vision/hearing) or traumatic experiences that are significant to educational history? ○ No ◉ Yes

If Yes, please explain:

Are you aware of having had any developmental delays age 0-5 years (speech, walking, toileting, socializing, reading)? ○ No ◉ Yes

If Yes, please explain:

List or describe any substance abuse history that created problems and / or consequences that occurred during school years:

College Graduate? ○ No ◉ Yes

If Yes, type of

Cultural / Spiritual History

Spiritual beliefs, upbringing and values within family of origin and how it affected you:

Do you have a spiritual belief, or a higher power? ○ No ◉ Yes

Explain

Are your beliefs and spiritual practices a significant part of your life? ○ No ◉ Yes

Do you attend formal religious / spiritual practice? ○ No ◉ Yes

Do you meditate or pray regularly? ○ No ◉ Yes

How has your substance abuse affected your spiritual aspect of life?

Do you feel your spiritual belief/higher power will have an impact on your recovery? ○ No ◉ Yes

If Yes, please describe:

History of cultural influences:

Are there any cultural, racial or ethnic background issues that will impact your recovery? ○ No ◉ Yes

If Yes, please explain in detail:

What is your cultural attitude toward substance abuse?

Sexual History / Orientation

Describe your current sexual orientation:

Have you always had the same sexual orientation: ○ No ◉ Yes

Age you became sexually active:

Was your participation consensual? ○ No ○ Yes

Explain:

If Yes, explain:

Have you had multiple sexual partners? ○ No ◉ Yes

If Yes, explain:

Have you ever engaged in unprotected sex? ○ No ◉ Yes

If Yes, explain:

Have you ever experienced gender identity issues? ○ No ◉ Yes

If Yes, explain:

Have you ever experienced Sexual Compulsivity / Addiction? ○ No ◉ Yes

Are you experiencing any guilt or shame regarding your sexual orientation and/or sexual practices? ○ No ◉ Yes

If Yes, please describe:

Recreation

Describe what type of recreation activities you have enjoyed:

During the past year, how often have you participated in these activities:

Has the frequency of these activities been affected by your relationship with substances? ○ No ◉ Yes

If Yes, explain:

Describe what type of recreation activities you would like to learn or start to engage in:

Employment History

Currently employed? ○ No ◉ Yes

If Yes, how long

If Yes, where and job title/description

Previous job history (types of jobs held, where, when and reason for leaving):

Ever had problems at work related to substance use: ○ No ◉ Yes

If Yes, explain

Has anyone at work expressed concern about your substance use? ○ No ◉ Yes

If Yes, please describe:

Does your employer require notification of your treatment? ○ No ◉ Yes

If Yes, provide employer's name, contact person's name, address and phone #:

If Yes, release signed from employer: ○ No ◉ Yes

Does someone contribute to your financial support? ○ No ◉ Yes

If Yes, explain:

Do people depend on you for basic needs (food, shelter, etc.)? ○ No ◉ Yes

If Yes, please explain:

Vocational interests and goals:

Would employment counseling be of interest to you now? ○ No ◉ Yes

Legal History

Legal problems: ○ No ○ Yes

Have you ever been arrested? ○ No ◉ Yes

If Yes, please give number of, dates of, reason for and disposition of arrest(s):

Pending charges? ○ No ◉ Yes

If Yes, what charges:

Upcoming court dates? ○ No ◉ Yes

If Yes, when? **Postponed?** ○ No ○ Yes

Have any of your charges resulted in convictions? ○ No ◉ Yes

If Yes, what charges and when?

Have you ever been incarcerated? ○ No ◉ Yes

If Yes, for how long?

Are you currently on probation or parole? ○ No ◉ Yes

If Yes, please explain:

If Yes, name and address of probation or parole officer:

Parole officer release signed: ○ No ◉ Yes

If Yes, do you have special probation, parole or court conditions regarding treatment? ○ No ○ Yes

If Yes, please explain:

Required to register under Megan's Law? ○ No ◉ Yes

Explain:

Would counseling for legal issues be of interest to you now? ○ No ◉ Yes

Military History

Have you ever been in the Armed Forces? ○ No ◉ Yes

If Yes, please provide dates of service, branch of service:

If Yes, have you experienced and trauma related to military service:

What was your highest rank?

Date and type of discharge:

Were you ever demoted due to substance use? ○ No ◉ Yes

If Yes, explain:

Are you eligible for Veteran's Administration benefits? ○ No ◉ Yes

Mental Status Summary

General Observations:

Interviewing Counselor's Interpretations

☐ neat	☐ dirty	☐ appears younger	☐ messy
☐ clean	☐ unkempt	☐ appears older	

Physical Attire:

☐ appropriate	☐ inappropriate	☐ well groomed	☐ flashy

General Manner:

☐ reserved	☐ shy	☐ tense	☐ suspicious
☐ apathetic	☐ embarrassed	☐ distant	☐ defiant
☐ resentful	☐ candid	☐ submissive	☐ high strung
☐ fragile	☐ grandiose	☐ monotone	☐ serious
☐ defensive	☐ irritable	☐ courteous	☐ cooperative
☐ indifferent	☐ perceptive	☐ hostile	

Thought Process:

☐ appropriate	☐ manipulative	☐ irrelevant	☐ vague
☐ calculating	☐ elusive	☐ indirect	☐ flight of ideas
☐ distractible	☐ spontaneous	☐ expressionless	☐ circumstantial
☐ disconnected	☐ mute	☐ tangential	☐ overly inclusive
☐ confronting	☐ sarcastic	☐ slow	☐ emotionless

Emotional Reactions:

☐ spontaneous ☐ apprehensive ☐ elated ☐ perplexed
☐ superficial ☐ dissatisfied ☐ depressed ☐ angry
☐ confused ☐ indifferent ☐ fearful ☐ anxious
☐ euphoric ☐ apathetic ☐ tearful

Speech:

☐ flat ☐ appropriate ☐ rambling
☐ pressured ☐ slurred

Affect:

☐ appropriate ☐ shallow ☐ incongruent ☐ blunt
☐ flat

Orientation:

☐ time ☐ person ☐ place ☐ situation

Hallucinations:

Hallucinations ○ No ○ Yes

Delusions

Delusions ○ No ○ Yes

Evaluative Summary

Motivation level is: ○ Precontemplation ○ Contemplation ○ Preparation ○ Action ○ Maintenance ○ Relapse

After meeting and reviewing medical, substance abuse, mental health and social history, client challenges (i.e., overuse of defense mechanisms, distrust, cognitive limitations, etc.) during treatment may include:

After meeting and reviewing medical, substance abuse, psychiatric and social history, client is likely to excel in the following areas during their treatment stay:

What approach (or combination of services) will most likely yield the most effective treatment outcome for this client?

Interpretive Summary

Client Composite (describe the central themes that will need to be addressed during the client's treatment, including the client's psychological assessment and any co-occurring disorders or disabilities):

Presenting Illness and Underlying Problems:

Recommended Program/Level of Care:

Client Strengths, Needs, Abilities and Preferences (Clinician's impressions):

Client Needs that will be Addressed in Treatment:

Client Needs that will NOT be Addressed in Treatment:

Support System:

Clinical Impressions:

Contact Signatures

Treatment Team Signatures