

BIOPSYCHOSOCIAL ASSESSMENT

Demographics Box

Client Name:		Date:	
Current Address: Street City/State Zip Code		Phone #: () -	
Date of Birth:		Marital/Relationship Status:	
Nation/Tribe/Ethnicity:			
Primary language of client:			Secondary:
Referral Source:			Phone:
Emergency Contact:			Phone:

Family Relationships

Does the client have any children?						
Name	Age	Date of Birth	Sex	Custody? Y/N	Lives With?	Additional Information
Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)						
Name	Age	Sex	Relationship	Additional Information		
Primary language of household/family:				Secondary:		

Critical Population (choose all that apply)

Funding Source	Residential	Legal Involvement
<input type="checkbox"/> Food Stamp Recipient	<input type="checkbox"/> Homeless	<input type="checkbox"/> Protective Services (APS/CPS)
<input type="checkbox"/> TANF Recipient	<input type="checkbox"/> Shelter Resident	<input type="checkbox"/> Court Ordered Services
<input type="checkbox"/> SSI Recipient	<input type="checkbox"/> Long Term Care Eligibility	<input type="checkbox"/> On Probation
<input type="checkbox"/> SSDI Recipient	<input type="checkbox"/> Long Term Care Resident	<input type="checkbox"/> On Parole
<input type="checkbox"/> SSA (retirement) Recipient	Disability	<input type="checkbox"/> On Pre-Release
<input type="checkbox"/> Other Retirement Income		<input type="checkbox"/> Mandatory Monitoring
<input type="checkbox"/> Medicaid Recipient	<input type="checkbox"/> Physical Disability	Other
<input type="checkbox"/> Medicare Recipient	<input type="checkbox"/> Severely Mentally Ill	
<input type="checkbox"/> General Assistance	<input type="checkbox"/> SED	<input type="checkbox"/> Currently pregnant
	<input type="checkbox"/> Developmentally Disabled	<input type="checkbox"/> Woman w/dependents
	<input type="checkbox"/> Chronically Mentally Ill	
	<input type="checkbox"/> Regional Behavioral Health Authority	

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Contact Information (Secure consents for agency contacts, when possible)		
Name of Caseworker	Agency	Phone number

Client's/Family's Presentation of the Problem:
Client's/Family's Expected Outcome:

Physical Realm	Yes	No
Client acknowledges he/she has caused damage to his/her body by abusing drugs, alcohol or food. <i>If yes, complete Behavioral Assessment</i>		
Client understands the connection between emotions, life stressors, sense of self and the effect these elements have on physical health.		
Client manages his/her anger effectively and does not inflict pain on himself/herself or others.		
Client engages in activities designed to maintain physical health. <i>Optional – Physical Fitness</i>		
Allergies (Medication and Other):		
Comments:		

Nutritional Screening

Nutritional Status: Current Weight			Current Height			BMI		
Appetite: <input type="checkbox"/> Good			<input type="checkbox"/> Fair			<input type="checkbox"/> Poor, please explain below		
<input type="checkbox"/> Recently gained/lost significant weight				<input type="checkbox"/> Binges/overeats to excess				
<input type="checkbox"/> Restricts food/Vomits/over-exercises to avoid weight gain				<input type="checkbox"/> Special dietary needs				
<input type="checkbox"/> Hiding/hording food				<input type="checkbox"/> Food allergies				
Comments:								

Pain Questionnaire

<p>Pain Management: Is the client in pain now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If yes, ask client to rate the pain on a scale of 1-10 (with 10 being the severest) and enter score here</p> <p style="padding-left: 40px;">Is the client receiving care for the pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If no, would the client like a referral for pain management? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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Behavioral Assessment

Abuse/Addiction – Chemical & Behavioral				
Drug	Age First Used	Age Heaviest Use	Recent Pattern of Use (frequency & Amount, etc)	Date Last Used
Alcohol				
Cannabis				
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, Phenobarb, etc)				
Designer Drugs/Other (herbal, Steroids, cough syrup, etc)				
Tobacco (smoke, chew)				
Caffeine				
Ever injected Drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Which ones?
Drug of Choice?				
Consequences as a Result of Drug/Alcohol Use (select all that apply)				
<input type="checkbox"/> Hangovers	<input type="checkbox"/> DTs/Shakes	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Binges	
<input type="checkbox"/> Overdoses	<input type="checkbox"/> Increased Tolerance (need more to get high)	<input type="checkbox"/> GI Bleeding	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Relationship Problems	<input type="checkbox"/> Left School	
<input type="checkbox"/> Lost Job	<input type="checkbox"/> DUIs	<input type="checkbox"/> Assaults	<input type="checkbox"/> Arrests	
<input type="checkbox"/> Incarcerations	<input type="checkbox"/> Homicide	<input type="checkbox"/> Other:		
Longest Period of Sobriety?			How long ago?	
Triggers to use (list all that apply):				
Has client traded sex for drugs?		<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain:	
Has client been tested for HIV?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, date of last test:		Results:		
Has client had any of the following problem gambling behaviors? Select all that apply:				
<input type="checkbox"/> Gambled longer than planned	<input type="checkbox"/> Gambled until last dollar was gone			
<input type="checkbox"/> Lost sleep thinking of gambling	<input type="checkbox"/> Used income or savings to gamble while letting bills go unpaid			
<input type="checkbox"/> Borrowed money to gamble	<input type="checkbox"/> Made repeated, unsuccessful attempts to stop gambling			
<input type="checkbox"/> Been remorseful after gambling	<input type="checkbox"/> Broken the law or considered breaking the law to finance gambling			
<input type="checkbox"/> Other:	<input type="checkbox"/> Gambled to get money to meet financial obligations			
Risk Taking/Impulsive Behavior (current/past) – select all that apply:				
<input type="checkbox"/> Unprotected sex	<input type="checkbox"/> Shoplifting	<input type="checkbox"/> Reckless driving		
<input type="checkbox"/> Gang Involvement	<input type="checkbox"/> Drug Dealing	<input type="checkbox"/> Carrying/using weapon		
<input type="checkbox"/> Other:				

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Leisure & Recreation

Which of the following does the client do? (Select all that apply)			
Spend Time with Friends		Sports/Exercise	
Classes		Dancing	
Time with Family		Hobbies	
Work Part-Time		Watch Movies/TV	
Go "Downtown"		Stay at Home	
Listen to Music		Spend Time at Clubs/Bars	
Go to Casinos		Other:	
What limits the client's leisure/recreational activities?			

Family History

Family History of (select all that apply):						
	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol/Substance Abuse						
History of Completed Suicide						
History of Mental Illness/Problems such as:						
Depression						
Schizophrenia						
Bipolar Disorder						
Alzheimer's						
Anxiety						
Attention Deficit/Hyperactivity						
Learning Disorders						
School Behavior Problems						
Incarceration						
Other						
Comments:						

Emotional Realm	Yes	No
Client has an understanding of his/her special relationship to Mother Earth.		
Client has an understanding of his/her relationship with Father Sky.		
Client has a sense of connectedness to the entire universe.		
Client is able to acknowledge all fears, desires, emotions, and feelings of distress & cares for his/her own spirit.		
Additional Information:		

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Educational Status Screening

Educational Level (select one): <input type="checkbox"/> less than 12 years – enter grade completed		<input type="checkbox"/> Some college or tech school
<input type="checkbox"/> Unknown	<input type="checkbox"/> High School Grad/GED	<input type="checkbox"/> College Graduate
If still attending, current School/Grade:		
Vocational School/Skill Area:		
College/Graduate School – Years Completed/Major:		

Functional Assessment

Functional Assessment:			
Is client able to care for him/herself? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain:			
Living Situation:			
<input type="checkbox"/> Housing Adequate	<input type="checkbox"/> Housing Dangerous	<input type="checkbox"/> Ward of State/Tribal Court	<input type="checkbox"/> Dependent on Others
<input type="checkbox"/> Housing Overcrowded	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Homeless	<input type="checkbox"/> At Risk of Homelessness
Additional Information:			
Uses or Needs assistive or adaptive devices (select all that apply):			
<input type="checkbox"/> None	<input type="checkbox"/> Glasses	<input type="checkbox"/> Walker	<input type="checkbox"/> Braille
<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Translated Written Information	<input type="checkbox"/> Translator for Speaking	<input type="checkbox"/> Other:	
Does the client have a history of falls? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:			

Vocational/Employment Screening

Employment: Currently Employed?			
<input type="checkbox"/> Yes	Employer	Length of Employment	
<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Supervisor Conflict	<input type="checkbox"/> Co-worker Conflict
<input type="checkbox"/> No	Last Employer:	Reason for Leaving:	
<input type="checkbox"/> Never Employed	<input type="checkbox"/> Disabled	<input type="checkbox"/> Student	<input type="checkbox"/> Unstable Work History
<input type="checkbox"/> Sheltered Employment		<input type="checkbox"/> Receiving Vocational Services	
Comments:			

Legal Status Screening

Past or current legal problems (select all that apply)?		
<input type="checkbox"/> None	<input type="checkbox"/> Gangs	<input type="checkbox"/> DUI/DWI
<input type="checkbox"/> Arrests	<input type="checkbox"/> Conviction	<input type="checkbox"/> Detention
<input type="checkbox"/> Jail	<input type="checkbox"/> Probation	<input type="checkbox"/> Other
If yes to any of the above, please explain:		
Any court-ordered treatment? <input type="checkbox"/> Yes (explain below) <input type="checkbox"/> No		
Ordered by	Offense	Length of Time

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Family Social History

Describe family relationships & desire for involvement in the treatment process:

Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive)

Spiritual Self	Yes	No
Client demonstrates a willingness to seek out new persons, places and experiences.		
Client expresses a desire to make a positive life change.		
Client seeks to balance his/her rights, needs and desires with those of others in order to achieve harmony.		
Client desires personal harmony, balance and freedom.		
Client seeks to strengthen his prayer life/belief system.		
Additional Information:		

Bereavement/Loss & Spiritual Awareness

Please list significant losses, deaths, abandonments, traumatic incidents:

Spiritual/Cultural Awareness & Practice

Knowledgeable about traditions, spirituality, or religion? Yes No Comment:

Practices traditions, spirituality, or religion? Yes No Comment:

How does client describe his/her spirituality?

Does client see a traditional healer? Yes No Comment:

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Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, medical, educational) or exploitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.			
Has client been abused at any time in the past or present by family, significant others, or anyone else?) <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:			
Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal Putdowns			
Being threatened			
Made to feel afraid			
Pushed			
Shoved			
Slapped			
Kicked			
Strangled			
Hit			
Forced or coerced into sexual activity			
Other			
Was it reported? <input type="checkbox"/> Yes <input type="checkbox"/> No	To whom?		
Outcome			
Has client ever witnessed abuse or family violence? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:			

Mental/Introspective Thought	Yes	No
Client believes that he is speaking honestly with him/herself.		
Client looks at both problems & accomplishments as an indicator of his/her sense of self		
Client examines the ways in which he/she has tried to manipulate, control or manage the lives of others.		
Client acknowledges that changes in his/her life must start with him/her.		
Additional Information:		

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Strengths/Resources (enter score if present) 1 = Adequate, 2 = Above Average, 3 = Exceptional		
Family Support	Social Support Systems	Relationship Stability
Intellectual/Cognitive Skills	Coping Skills & Resiliency	Parenting Skills
Socio-Economic Stability	Communication Skills	Insight & Sensitivity
Maturity & Judgment Skills	Motivation for Help	Other:
Comments:		
Describe appropriateness & level of need for the family's participation:		

Mental Status Exam

Category	Selections
GENERAL OBSERVATIONS	
Appearance	<input type="checkbox"/> Well groomed <input type="checkbox"/> Unkempt <input type="checkbox"/> Disheveled <input type="checkbox"/> Malodorous
Build	<input type="checkbox"/> Average <input type="checkbox"/> Thin <input type="checkbox"/> Overweight <input type="checkbox"/> Obese
Demeanor	<input type="checkbox"/> Cooperative <input type="checkbox"/> Hostile <input type="checkbox"/> Guarded <input type="checkbox"/> Withdrawn
	<input type="checkbox"/> Preoccupied <input type="checkbox"/> Demanding <input type="checkbox"/> Seductive
Eye Contact	<input type="checkbox"/> Average <input type="checkbox"/> Decreased <input type="checkbox"/> Increased
Activity	<input type="checkbox"/> Average <input type="checkbox"/> Decreased <input type="checkbox"/> Increased
Speech	<input type="checkbox"/> Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Rapid <input type="checkbox"/> Slow
	<input type="checkbox"/> Pressured <input type="checkbox"/> Soft <input type="checkbox"/> Loud <input type="checkbox"/> Monotone
	Describe:
THOUGHT CONTENT	
Delusions	<input type="checkbox"/> None Reported <input type="checkbox"/> Grandiose <input type="checkbox"/> Persecutory <input type="checkbox"/> Somatic
	<input type="checkbox"/> Bizarre <input type="checkbox"/> Nihilist <input type="checkbox"/> Religious
	Describe:
Other	<input type="checkbox"/> None Reported <input type="checkbox"/> Poverty of Content <input type="checkbox"/> Obsessions <input type="checkbox"/> Compulsions
	<input type="checkbox"/> Phobias <input type="checkbox"/> Guilt <input type="checkbox"/> Anhedonia <input type="checkbox"/> Thought Insertion
	<input type="checkbox"/> Ideas of Reference <input type="checkbox"/> Thought Broadcasting
	Describe:
Self Abuse	<input type="checkbox"/> None Reported <input type="checkbox"/> Self Mutilization
	<input type="checkbox"/> Suicidal (assess lethality if present) <input type="checkbox"/> Intent <input type="checkbox"/> Plan
Aggressive	<input type="checkbox"/> None Reported <input type="checkbox"/> Aggressive (assess lethality of present)
	<input type="checkbox"/> Intent <input type="checkbox"/> Plan
PERCEPTION	
Hallucinations	<input type="checkbox"/> None Reported <input type="checkbox"/> Auditory <input type="checkbox"/> Visual
	<input type="checkbox"/> Olfactory <input type="checkbox"/> Gustatory <input type="checkbox"/> Tactile
	Describe:
Other	<input type="checkbox"/> None Reported <input type="checkbox"/> Illusions <input type="checkbox"/> Depersonalization <input type="checkbox"/> Derealization
THOUGHT PROCESS	
<input type="checkbox"/> Logical	<input type="checkbox"/> Goal Oriented <input type="checkbox"/> Circumstantial <input type="checkbox"/> Tangential
<input type="checkbox"/> Loose	<input type="checkbox"/> Rapid Thoughts <input type="checkbox"/> Incoherent <input type="checkbox"/> Concrete
<input type="checkbox"/> Blocked	<input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Pervasive <input type="checkbox"/> Derailment
Describe:	

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MOOD			
<input type="checkbox"/> Euthymic	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	
<input type="checkbox"/> Angry	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Irritable	
AFFECT			
<input type="checkbox"/> Flat	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Labile	<input type="checkbox"/> Blunted
<input type="checkbox"/> Congruent with Mood		<input type="checkbox"/> Full	<input type="checkbox"/> Constricted
BEHAVIOR			
<input type="checkbox"/> No behavior issues		<input type="checkbox"/> Assaultive	<input type="checkbox"/> Resistant
<input type="checkbox"/> Aggressive		<input type="checkbox"/> Agitated	<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Restless		<input type="checkbox"/> Sleepy	<input type="checkbox"/> Intrusive
MOVEMENT			
<input type="checkbox"/> Akathisia	<input type="checkbox"/> Dystonia	<input type="checkbox"/> Tardive Dyskinesia	<input type="checkbox"/> Tics
Describe:			
COGNITION			
Impairment of:	<input type="checkbox"/> None Reported		<input type="checkbox"/> Orientation
	<input type="checkbox"/> Attention/Concentration		<input type="checkbox"/> Ability to Abstract
	Describe:		
Intelligence Estimate	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Borderline	<input type="checkbox"/> Average
IMPULSE CONTROL	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent
INSIGHT	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent
JUDGMENT	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent

RISK ASSESSMENT				
Risk to Self	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Chronic
Risk to Others	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Chronic
Serious current risk of any of the following: (Immediate response needed)				
Abuse or Family Violence		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abuse or Family Violence
Psychotic or Severely Psychologically Disabled		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is there a handgun in the home?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any other weapons?
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Plan:				
Safety Plan Reviewed				
<input type="checkbox"/> Yes <input type="checkbox"/> No				

Diagnoses and Interpretive Summary

Biopsychosocial formulation	
DSM IV-TR Provisional Diagnoses	
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	
Treatment Acceptance/Resistance	
Client accepts problem? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:	
Client recognizes need for treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:	
Client minimizes or blames others? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:	
External motivation is primary? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:	

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Preliminary Treatment Plan & Referrals

Preliminary Biopsychosocial Treatment Plan			
Biological:			
Psychological:			
Social/Environmental:			
Referrals			
<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Medical Provider	<input type="checkbox"/> Spiritual Counselor
<input type="checkbox"/> Benefits Coordinator	<input type="checkbox"/> Nutritionist	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Vocational Counselor
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Community Agency:	<input type="checkbox"/> Other:	

Physical Fitness (optional)

Physical Activity (please select one of the following based on activity level for the past month):

Avoids walking or exertion, e.g. always uses elevator, drives whenever possible instead of walking.

Walks for pleasure, routinely uses stairs, occasionally exercises sufficiently to cause heavy breathing or perspiration.

Participates regularly in recreation or work requiring **modest physical activity** such as golf, horseback riding, calisthenics, gymnastics, table tennis, bowling, weight lifting, and yard work.

10-60 minutes per week
 More than one hour per week

Participates regularly in **heavy physical exercise**, such as running, jogging, swimming, cycling, rowing, skipping rope, running in place or engaging in vigorous aerobic activity such as tennis, basketball or handball.

Runs less than a mile a week or engages in other exercise for less than 30 minutes per week
 Runs 1-5 miles per week or engages in other exercise for 30-60 minutes per week
 Runs 5-10 miles per week or engages in other exercise for 1-3 hours per week
 Runs more than 10 miles per week or engages in other exercise for more than 3 hours per week