

Biopsychosocial Assessment

Personal Information

First Name	Last Name	Date of Birth	Ethnicity
Current Physician Name		Current Physician Email	Current Physician Number

What are your goals for therapy

Risk Screening

Are you pregnant or trying to be?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable
Have you ever contemplated suicide?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable
Do you currently engage in unsafe sex or use needles?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable
Are you a survivor of trauma?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable

Presenting Problem

Please describe the problem(s) that has led you to seek treatment

How long have you been experiencing this problem?

Please list the symptoms you currently experience or have experienced in the past as a result of this problem

What impact does this problem have on your day-to-day life?

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Medical History

Please list any current or past medications

Medication Name	Dose	Frequency	Indication	Note

Please list any past or current medical conditions

Please list any medical or food allergies

Have you ever been hospitalized? If so, what for?

Psychiatric History

Have you ever seen a mental health professional before? If so, what for?

Has anyone in your family ever been treated for a psychiatric/mental health disorder? If yes, please specify

Have you ever received treatment for mental health issues, substance use, or emotional issues? If yes, please describe

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Substance Use/Addiction History

Please include alcohol, caffeine, tobacco, illegal drugs or pills, and any other substances you currently use or have used in the past in the below table:

Substance	Age of First Use	Frequency	Date of Last Use	Note

Do you have any problems with other addictions? (e.g. gambling, pornography, food, shopping)

Have you ever sought treatment for substance use or addiction? (e.g. self-help group, 12-step program)

Is there any history of addiction/substance abuse in your family?

Social

Please list your family members (e.g. parents, children, spouse, siblings)

Please describe the relationships you have with your family members

Please describe the relationships you have with friends or extended family members

Do you have any close friends?

Have you ever had any problems with friendships?

What is your current relationship status? Single Married Divorce Other:

Have you ever had problems with your marriage/relationships?

Please describe your current living situation

What do you like to do for fun?

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Developmental

Were there any problems when your Mother was pregnant with you?

Did you have any health issues or behavioral problems in childhood?

What was your home and family environment like as a child?

Education and Employment

What is the highest educational level you have achieved?

What is your current employment status? Employed Unemployed Part-time Other:

Please describe your work history (e.g. what kind of work, how long for)

Have you ever had conflicts at work?

Legal

Have you ever been arrested? Yes No

If No, please skip the rest of this section.

How many times?

What were you arrested for?

Have you ever served a prison sentence? If yes, please describe below (e.g. when, how long for)

Additional Note

Is there anything else you would like me to know about you that you haven't already included