

BIOPSYCHOSOCIAL ASSESSMENT

Demographics

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:	

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		<input type="checkbox"/> On Pre-Release
<input type="checkbox"/> Other Retirement Income	Disability	<input type="checkbox"/> Mandatory Monitoring
<input type="checkbox"/> Medicaid Recipient	<input type="checkbox"/> Physical Disability	
<input type="checkbox"/> Medicare Recipient	<input type="checkbox"/> Severely Mentally Ill	Other
<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	
Contact Information (Secure consents for agency contacts, when possible)		
Name of Caseworker	Agency	Phone number

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:			

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Nutrition

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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Family History

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

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Social	Yes	No
Client reports satisfaction with his/her family relationships.	<input type="checkbox"/>	<input type="checkbox"/>
Client reports satisfaction with his/her social relationships and activities.	<input type="checkbox"/>	<input type="checkbox"/>
Client reports satisfaction with the entertainment/recreational activities he/she selects.	<input type="checkbox"/>	<input type="checkbox"/>
Client expresses an interest in his community and the world, in general.	<input type="checkbox"/>	<input type="checkbox"/>
Client has a history of or current legal involvement. <i>If Yes), complete Legal Status Screening.</i>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

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"/> Housing Overcrowded	<input type="checkbox"/> Homeless
<input type="checkbox"/> Dependent Upon Others	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Ward of State/Tribal Court	
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:			

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

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:		

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Leisure & Recreation

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

Family Social History

<p>Describe family relationships & desire for involvement in the treatment process:</p> <p>Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive)</p>
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Psychological	Yes	No
Client accepts responsibility for creating his/her own feelings.	<input type="checkbox"/>	<input type="checkbox"/>
Client accepts responsibility for his/her own actions.	<input type="checkbox"/>	<input type="checkbox"/>
Client makes decisions with a minimum of stress and worry.	<input type="checkbox"/>	<input type="checkbox"/>
Client is able to express feelings of anger, disappointment, frustration, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Client reports a stable emotional life.	<input type="checkbox"/>	<input type="checkbox"/>
Client feels enthusiastic about his/her life.	<input type="checkbox"/>	<input type="checkbox"/>
Client reports adequate energy level.	<input type="checkbox"/>	<input type="checkbox"/>
Client reports sleep is restful & adequate.	<input type="checkbox"/>	<input type="checkbox"/>
Client reports he/she feels positive about self.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

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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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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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Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, medical, educational) or exploitation? <input type="checkbox"/> No <input type="checkbox"/> Yes 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:			

Strengths/Weaknesses	Yes	No
Client is able to seek out appropriate resources for assistance with identified problems.	<input type="checkbox"/>	<input type="checkbox"/>
Client is able to identify both his/her strengths and weaknesses.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		
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:		

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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"/> 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:				
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"/> Memory
	<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	<input type="checkbox"/> Above 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	

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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 <input type="checkbox"/> Yes <input type="checkbox"/> No		
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:	

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:

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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