

## BIOPSYCHOSOCIAL ASSESSMENT

### Demographics

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

### Family Relationships

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

### Family History

<b>Family History of (select all that apply):</b>						
	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"/>					
<b>Comments:</b>						

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**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	<b>Disability</b>	<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	<b>Other</b>
<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

**Client's/Family's Presentation of the Problem:**

**Client's/Family's Expected Outcome:**

**Physical Functioning**

**Allergies (Medication & Other):**

**Current Medical Conditions:**

**Current Medications (include herbs, vitamins, & over-the-counter):**

**Past Medications:**

**Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including RTC, group home, therapeutic foster care, aftercare, inpatient psychiatric, outpatient counseling):**

Dates	Inpt/Outpt	Location	Reason	Completed? Y/N

**Surgeries:**

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### Pain Questionnaire

<p><b>Pain Management:</b> Is the client in pain now? <input type="checkbox"/> Yes <input type="checkbox"/> No                  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="text-align: center;">Is the client receiving care for the pain? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If no, would the client like a referral for pain management? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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### Nutrition

<b>Nutritional Status:</b> Current Weight			Current Height			BMI		
<b>Appetite:</b> <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					
<b>Comments</b>								

### Social

<b>Supportive Social Network?</b> (Rate the network using a scale of 1 Weak to 5 Strong)			
Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	
<b>Comment:</b>			
<b>Living Situation:</b>			
<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
<b>Additional Information:</b>			
<b>Employment: Currently Employed?</b>			
<input type="checkbox"/> Yes	<b>Employer</b>	<b>Length of Employment</b>	
<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Supervisor Conflict	<input type="checkbox"/> Co-worker Conflict
<input type="checkbox"/> No	<b>Last Employer:</b>	<b>Reason for Leaving:</b>	
<input type="checkbox"/> Never Employed	<input type="checkbox"/> Disabled	<input type="checkbox"/> Student	<input type="checkbox"/> Unstable Work History
<b>Financial Situation:</b>			
<b>Presence or absence of financial difficulties: (Fields below are optional)</b>			
<input type="checkbox"/> No Current Problems	<input type="checkbox"/> Large Indebtedness	<input type="checkbox"/> Relationship Conflicts Over Finances	
<input type="checkbox"/> Impulsive Spending	<input type="checkbox"/> Poverty or Below	<input type="checkbox"/> Financial Difficulties	
<b>Source of Income (choose all that apply)</b>			
Employed: <input type="checkbox"/> Full-time		Unemployed: <input type="checkbox"/> Public Assistance	
<input type="checkbox"/> Seasonal		<input type="checkbox"/> Actively seeking work	
<input type="checkbox"/> Part-time		<input type="checkbox"/> Not looking for work	
<input type="checkbox"/> Temporary			
<input type="checkbox"/> Self-Employed			
<input type="checkbox"/> Retirement	<input type="checkbox"/> SSD	<input type="checkbox"/> SSDI	<input type="checkbox"/> SSI
<input type="checkbox"/> Medical Disability via Employer		<input type="checkbox"/> Other:	
<b>Military History:</b>			
<input type="checkbox"/> Never enlisted in Armed Forces, OR			
<input type="checkbox"/> Branch of Service:		<b>Combat:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Type of Discharge:</b>		<input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable <input type="checkbox"/> Medical <input type="checkbox"/> Other:	
<b>Sexual Orientation:</b>			
<input type="checkbox"/> Heterosexual		<input type="checkbox"/> Bisexual	
<input type="checkbox"/> Homosexual		<input type="checkbox"/> Transgendered	
<input type="checkbox"/> N/A at this time		<input type="checkbox"/> Comment:	

## BIOPSYCHOSOCIAL ASSESSMENT

### 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)

### 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?  Yes (explain below)  No

Ordered by	Offense	Length of Time

### Education

Educational Level (select one):  less than 12 years – enter grade completed  Some college or tech school

Unknown  High School Grad/GED  College Graduate

If still attending, current School/Grade:

Vocational School/Skill Area:

College/Graduate School – Years Completed/Major:

### Leisure & Recreation

Which of the following does the client do? (Select all that apply)

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:	<input type="checkbox"/>

What limits the client's leisure/recreational activities?

### Functional Assessment

Is client able to care for him/herself?  Yes  No If No, please explain:

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?  Yes  No Explain:

## BIOPSYCHOSOCIAL ASSESSMENT

### Psychological

History of Depressed Mood:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of irritability, anger or violence (tantrums, hurts others, cruel to animals, destroys property):			
<b>Sleep Pattern:</b> Number of hours per day                      Time to onset of sleep?			
<input type="checkbox"/> Normal	<input type="checkbox"/> Sleeping too much	<input type="checkbox"/> Sleeping too little	
<b>Ability to Concentrate:</b>		<input type="checkbox"/> Normal	<input type="checkbox"/> Difficulty concentrating
<b>Energy Level:</b>		<input type="checkbox"/> Low	<input type="checkbox"/> Average/Normal <input type="checkbox"/> High
<b>History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal)?</b> Select all that apply			
<input type="checkbox"/> Intrusive memories, thoughts, perceptions	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Flashbacks	
<input type="checkbox"/> Avoiding thoughts, feelings, conversations	<input type="checkbox"/> Numbing/detachment	<input type="checkbox"/> Restricted display of emotions	
<input type="checkbox"/> Avoiding people, places, activities	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Irritability	
<input type="checkbox"/> Hypervigilance	<input type="checkbox"/> Other:		
<b>Any additional information:</b>			

### Bereavement/Loss & Spiritual Awareness

Please list significant losses, deaths, abandonments, traumatic incidents:	
<b>Spiritual/Cultural Awareness &amp; Practice</b>	
Knowledgeable about traditions, spirituality, or religion? <input type="checkbox"/> Yes <input type="checkbox"/> No    Comment:	
Practices traditions, spirituality, or religion? <input type="checkbox"/> Yes <input type="checkbox"/> No    Comment:	
How does client describe his/her spirituality?	
Does client see a traditional healer? <input type="checkbox"/> Yes <input type="checkbox"/> No    Comment:	

## BIOPSYCHOSOCIAL ASSESSMENT

### 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:			

## BIOPSYCHOSOCIAL ASSESSMENT

### 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				
<b>Ever injected Drugs?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If Yes, Which ones?</b>
<b>Drug of Choice?</b>				
<b>Consequences as a Result of Drug/Alcohol Use (select all that apply)</b>				
<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:		
<b>Longest Period of Sobriety?</b>			<b>How long ago?</b>	
<b>Triggers to use (list all that apply):</b>				
<b>Has client traded sex for drugs?</b>		<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain:	
<b>Has client been tested for HIV?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>If yes, date of last test:</b>			<b>Results:</b>	
<b>Has client had any of the following problem gambling behaviors? Select all that apply:</b>				
<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			
<b>Risk Taking/Impulsive Behavior (current/past) – select all that apply:</b>				
<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:				

# BIOPSYCHOSOCIAL ASSESSMENT

## Mental Status Exam

Category	Selections			
<b>GENERAL OBSERVATIONS</b>				
<b>Appearance</b>	<input type="checkbox"/> Well groomed	<input type="checkbox"/> Unkempt	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Malodorous
<b>Build</b>	<input type="checkbox"/> Average	<input type="checkbox"/> Thin	<input type="checkbox"/> Overweight	<input type="checkbox"/> Obese
<b>Demeanor</b>	<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	
<b>Eye Contact</b>	<input type="checkbox"/> Average	<input type="checkbox"/> Decreased	<input type="checkbox"/> Increased	
<b>Activity</b>	<input type="checkbox"/> Average	<input type="checkbox"/> Decreased	<input type="checkbox"/> Increased	
<b>Speech</b>	<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:				
<b>THOUGHT CONTENT</b>				
<b>Delusions</b>	<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:				
<b>Other</b>	<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:				
<b>Self Abuse</b>	<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	
<b>Aggressive</b>	<input type="checkbox"/> None Reported	<input type="checkbox"/> Aggressive (assess lethality of present)		
	<input type="checkbox"/> Intent	<input type="checkbox"/> Plan		
<b>PERCEPTION</b>				
<b>Hallucinations</b>	<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:			
<b>Other</b>	<input type="checkbox"/> None Reported	<input type="checkbox"/> Illusions	<input type="checkbox"/> Depersonalization	<input type="checkbox"/> Derealization
<b>THOUGHT PROCESS</b>				
<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"/> Perserverative	<input type="checkbox"/> Derailment	
Describe:				
<b>MOOD</b>				
<input type="checkbox"/> Euthymic	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious		
<input type="checkbox"/> Angry	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Irritable		
<b>AFFECT</b>				
<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		
<b>BEHAVIOR</b>				
<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		
<b>MOVEMENT</b>				
<input type="checkbox"/> Akathisia	<input type="checkbox"/> Dystonia	<input type="checkbox"/> Tardive Dyskinesia	<input type="checkbox"/> Tics	
Describe:				
<b>COGNITION</b>				
<b>Impairment of:</b>	<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:				
<b>Intelligence Estimate</b>	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Borderline	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
<b>IMPULSE CONTROL</b>		<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent
<b>INSIGHT</b>		<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent
<b>JUDGMENT</b>		<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent

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<b>RISK ASSESSMENT</b>				
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
<b>Serious current risk of any of the following: (Immediate response needed)</b>				
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		
<b>Plan:</b>				
Safety Plan Reviewed <input type="checkbox"/> Yes <input type="checkbox"/> No				

### Diagnoses and Interpretive Summary

<b>Biopsychosocial formulation</b>		
<b>DSM IV-TR Provisional Diagnoses</b>		
<b>Axis I</b>		
<b>Axis II</b>		
<b>Axis III</b>		
<b>Axis IV</b>		
<b>Axis V</b>		
<b>Treatment Acceptance/Resistance</b>		
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:		
<b>Strengths/Resources</b> (enter score if present) <b>1 = Adequate, 2 = Above Average, 3 = Exceptional</b>		
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:
<b>Comments:</b>		
<b>Describe appropriateness &amp; level of need for the family's participation:</b>		

## BIOPSYCHOSOCIAL ASSESSMENT

### Preliminary Treatment Plan & Referrals

Preliminary Biopsychosocial Treatment Plan			
<b>Biological:</b>			
<b>Psychological:</b>			
<b>Social/Environmental:</b>			
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)

<p><b>Physical Activity (please select one of the following based on activity level for the past month):</b></p> <p><input type="checkbox"/> Avoids walking or exertion, e.g. always uses elevator, drives whenever possible instead of walking.</p> <p><input type="checkbox"/> Walks for pleasure, routinely uses stairs, occasionally exercises sufficiently to cause heavy breathing or perspiration.</p> <p>Participates regularly in recreation or work requiring <b>modest physical activity</b> such as golf, horseback riding, calisthenics, gymnastics, table tennis, bowling, weight lifting, and yard work.</p> <p style="margin-left: 20px;"> <input type="checkbox"/> 10-60 minutes per week  <input type="checkbox"/> More than one hour per week         </p> <p>Participates regularly in <b>heavy physical exercise</b>, such as running, jogging, swimming, cycling, rowing, skipping rope, running in place or engaging in vigorous aerobic activity such as tennis, basketball or handball.</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Runs less than a mile a week or engages in other exercise for less than 30 minutes per week  <input type="checkbox"/> Runs 1-5 miles per week or engages in other exercise for 30-60 minutes per week  <input type="checkbox"/> Runs 5-10 miles per week or engages in other exercise for 1-3 hours per week  <input type="checkbox"/> Runs more than 10 miles per week or engages in other exercise for more than 3 hours per week         </p>
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