CHILD, YOUTH AND FAMILY STUDIES
Couple and Family Clinic

BIOPSYCHOSOCIAL ASSESSMENT – ADULT

Today's Date _____ Name _____

Date of Birth _____ Email Address _____

Preferred Language _____ Do you need an Interpreter? ☐Yes ☐No

Please complete this form in its entirety. If you wish not to disclose personal information, please check "No Answer" (NA).

PRESENTING PROBLEM

1. Please describe what brings you in today? _____
2. How long have you been experiencing this problem? ☐Less than 30 day ☐1-6 months ☐1-5 years ☐5+ years
3. Rate the intensity of the problem 1 to 5 (1 being mild and 5 being severe): ☐1 ☐2 ☐3 ☐4 ☐5
4. How is the problem interfering with your day-to-day functioning? _____
5. What are your current goals for therapy? If treatment were to be successful, what would be different?

   _____

   _____

6. Are you currently or in the last 30 days experienced any of the following symptoms? (*check all that apply*)

☐ Sadness	☐ Hopeless/Helpless	☐ Sleep Too Much	☐ Fatigue/No Energy	☐ Poor Memory
☐ No Motivation	☐ Lack of Interest	☐ Thoughts of Dying	☐ Guilt	☐ Feel Worthless
☐ Not Hungry	☐ Prefer Being Alone	☐ Irritable/ Angry	☐ Can't Sleep	☐ Too Much Energy
☐ No Need for Sleep	☐ Talk Too Fast	☐ Impulsive	☐ Can't Concentrate	☐ Restless/Can't Sit Still
☐ Suspicious	☐ Hearing Things	☐ Seeing Things	☐ Have Special Powers	☐ People Watching Me
☐ People Out to Get Me	☐ Feeling Nervous	☐ Fearful	☐ Panic Attacks	☐ Can't be in Crowds
☐ Easily Startled	☐ Avoidance	☐ Re-occurring Nightmares		

	Yes	No	NA
7. Do you now or have you ever contemplated suicide?.....	☐	☐	☐
8. Are you a survivor of trauma?.....	☐	☐	☐
9. Are you pregnant now?.....	☐	☐	☐
10. If yes, when are you due? (day/month/year) _____			
11. Are you at risk for HIV/AIDS/Sexually Transmitted Diseases (unsafe sex, using needles?)	☐	☐	☐
12. Please list allergies to medications or food: _____			
13. Has your physical health kept you from participating in activities?.....	☐	☐	☐

For staff use only:

Client Name: _____ Client Number: _____

TOBACCO

	Yes	No	NA
1. Have you ever used any forms of tobacco (cigarettes, snuff, etc.)? **IF NO SKIP TO NEXT SECTION**……	1. ☐	☐	☐
2. Are you a former tobacco user?.....	2. ☐	☐	☐

3. If yes, what form(s) of tobacco have you used in the past (*please check all that apply*)

☐ Cigarettes ☐ Cigars ☐ Snuff ☐ Chewing Tobacco ☐ Snuff ☐ Other

4. How many times on an average day do you use tobacco (1-99)?

Cigarettes____ Cigars____ Snuff____ Chewing Tobacco____ Snuff____

5. Have you been involved in a program to help you quit using tobacco in the past 30 days?.....	5. ☐	☐	☐

6. If so, which self-help group was used?_____

SUBSTANCE USE/ADDICTION <u>PRESENT</u>

	Yes	No	NA
1. Would you or someone you know say you are having a problem with alcohol?.....	1. ☐	☐	☐
2. Would you or someone you know say you are having problems with pills or illegal drugs?.....	2. ☐	☐	☐
3. Would you or someone you know say you are having problems with other addictions, ie. gambling, pornography or shopping?.....	3. ☐	☐	☐
4. Have you ever been to a self-help group?.....	4. ☐	☐	☐

SUBSTANCE USE/ADDICTION <u>PAST</u>

	Yes	No	NA
1. Would you or someone you know say you had a problem with alcohol?.....	1. ☐	☐	☐
2. Would you or someone you know say you had problems with pills or illegal drugs?.....	2. ☐	☐	☐
3. Would you or someone you know say you had problems with other addictions, ie. gambling, pornography or shopping?.....	3. ☐	☐	☐
4. Is there a family history of addiction in your family?.....	4. ☐	☐	☐

5. If yes, please describe: _____

PERSONAL, FAMILY AND RELATIONSHIPS

	Yes	No	NA
1. Who is in your family? (parents, brothers, sisters, children, etc.)_____			
2. Has there been any significant person or family member enter or leave your life in the last 90 days?.....	2. ☐	☐	☐

	Good	Fair	Poor	Close	Stressful	Distant	Other
3. How are the relationships in your family?.....	☐	☐	☐	☐	☐	☐	☐
4. How are the relationships in your support system (friends, extended family, et.?)……	☐	☐	☐	☐	☐	☐	☐

	Conflict	Abuse	Stress	Loss	Other
5. Are there any problems in your family now? (check all that apply)……	☐	☐	☐	☐	☐
6. Were there any problems with your family in the past? (check all that apply)……	☐	☐	☐	☐	☐
7. Are there any problems in your support system now? (check all that apply)……	☐	☐	☐	☐	☐
8. Were there any problems with your support system in the past? (check all that apply)……	☐	☐	☐	☐	☐

9. What is your marital status now? ☐ Single ☐ Married ☐ Living as Married ☐ Divorced ☐ Widowed ☐ Never Married

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Client Name: _____ Client Number: _____

	Yes	No	NA
10. Have you ever had problems with marriage/relationships?..... 10.	☐	☐	☐

11. If yes, please check why ☐Stress ☐Conflict ☐Loss ☐Divorced/Separation ☐Trust Issues ☐Other_____

12. Do you have any close friends?..... 12.	☐	☐	☐
13. Do you have problems with friendships?..... 13.	☐	☐	☐
14. Do you get along well with others (neighbors, co-workers, etc.)?..... 14.	☐	☐	☐

15. What do you like to do for fun? _____

EDUCATION

	Yes	No	NA

1. What is the highest grad you completed in school? (please check)
☐No Education ☐K-5 ☐6-8 ☐9-12 ☐GED ☐College Degree ☐Masters Degree
2. Would you describe your school experience as positive or negative?_____

3. Are you currently in school or a training program?..... 3.	☐	☐	☐

LEGAL

	Yes	No	NA
1. Have you ever been arrested? **IF NO SKIP TO NEXT SECTION**..... 1.	☐	☐	☐
2. In the past month?..... 2.	☐	☐	☐

3. If yes, how many times? _____

4. In the past year?..... 4.	☐	☐	☐

5. If yes, how many times? _____
6. If yes, what were you arrested for? _____
7. What was the name of your attorney? _____

8. Were you ever sentenced for a crime?..... 8.	☐	☐	☐

9. If yes, number of prison sentences served? _____
10. What year(s) did this occur? _____

11. Are you currently or have you ever been on probation or parole?..... 11.	☐	☐	☐

12. If yes, what is the name of your attorney or probation officer? _____

WORK

	Yes	No	NA

1. What is your work history like? ☐Good ☐Poor ☐Sporadic ☐Other
2. How long do you normally keep a job? ☐Weeks ☐Months ☐Years

3. Are you retired?..... 3.	☐	☐	☐

4. If yes, what kind of work do you do/did you do in the past? _____

5. Have you ever served in the military?..... 5.	☐	☐	☐

6. If yes, are you ☐Active ☐Retired ☐Other

MEDICAL

1. Current Primary Care Physician: _____Phone_____
2. Past and Current Medical/Surgical Problems: _____
3. Past and Current Medications and Dosages: _____
_____
4. Have you seen a Mental Health Professional Before? ☐ Yes ☐ No
5. If yes, Name, When, and Reason for Changing: _____
6. Current Psychiatrist/APRN, if applicable:_____
7. **Is there anything else you would like me to know about you?**_____
_____

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