Client Name: _______________________ Client ID#:___________________ Client SS#_________________ Date: __________

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems	**Duration** (months)	**Additional information:**
____________________________	_________________	____
____________________________	_________________	____
____________________________	_________________	____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-today functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	Anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	Breathing problems	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	Grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other specify_________	[ ]	[ ]	[ ]	[ ]

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] **Prior outpatient psychotherapy?**
No Yes If yes, on ___ occasions. Longest treatment by _____________________ for ___ from ______/______ to ______/______
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
______________________	____________	________	________________	_______________	__________________	_______________
______________________	____________	________	________________	_______________	__________________	_______________

Client Name: _________________________ Client ID#:___________________ Client SS#__________________ Date: ______________

[ ] [ ] **Has any family member had outpatient psychotherapy?** If yes, who/why (list all): ___________________________
No Yes ____

[ ] [ ] **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**
No Yes If yes, on ______occasions. Longest treatment at ________________________________from _____/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____________	_________	_______	____________	___________	_____________	__________
_____________	_________	_______	____________	___________	_____________	__________

[ ] [ ] **Has any family member had inpatient treatment for psychiatric, emotional, or substance use disorder? If yes,**
No Yes Who/why (list all)____

[ ] [ ] **Prior or current psychotropic medication usage?** If yes?

No Yes Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?
___________	_________	_________	______	_____	_________	___________	_______________

[ ] [ ] **Has any family member used psychotropic medications?** If yes, who/what/why (list all):
No Yes ____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

____

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] live in for ___ years
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ____

Describe parents:

	Father	**Mother**
full name:	____________	______________
occupation	____________	______________
education	_____________	______________
general health	__________	______________

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse towards others
[ ] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ **Circumstances:**____
____
____
____

Special circumstances in childhood:
____
____
____

IMMEDIATE FAMILY

Marital status:

[ ] single, never married
[ ] engaged ___ months
[ ] married for ___ years
[ ] divorced for ___ years
[ ] separated for ___ years
[ ] divorce in process ___ months
[ ] live-in for ___ years
[ ] prior marriages (self)
[ ] prior marriages (partner)

Intimate relationship:

[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in serious relationship

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in client's household:

Name	Age	Sex	Relationship to client
_____________	____	____	____________________
_____________	____	____	____________________

List children not living in same household as client:

_____________	_____	_____	____________________
_____________	_____	_____	____________________
_____________	_____	_____	____________________

Frequency of visitation of above: _________________________

Client Name: ________________________ Client ID#:__________________ Client SS#__________________ Date: ____________

Describe any past or current significant issues in intimate relationships:____
____
____

Describe any past or current significant issues in other immediate family relationships:__________________________________
____
____
____

MEDICAL HISTORY (check all that apply for client)

Describe current physical health [ ] Good [ ] Fair [ ] Poor
____

List name of primary care physician
Name: _______________________ Phone_______________

List name of psychiatrist (if any):
Name: _______________________ Phone_______________

List any medications currently being taken (give dosage & reason):
____
____

List any known allergies:_____________________________

List any abnormal lab test results:
Date: ____________ Result___________________
Date: ____________ Result___________________

Is there a history of any of the following in the family:
[ ] tuberculosis [ ] heart disease
[ ] birth defects [ ] high blood pressure
[ ] emotional problems [ ] alcoholism
[ ] behavior problems [ ] drug abuse
[ ] thyroid problems [ ] diabetes
[ ] cancer [ ] Alzheimer's disease/dementia
[ ] mental retardation [ ] stroke
[ ] other serious health problems ______________________________

Describe any serious hospitalization or accidents:

Date:_______________ Age____ Reason_____________________
Date: _______________ Age____ Reason_____________________

SUBSTANCE USE HISTORY (check all that apply for client)

Family alcohol/drug abuse history:

[ ] father
[ ] mother
[ ] grandparent(s)
[ ] sibling(s)
[ ] other _________________
[ ] stepparent/live-in
[ ] uncle(s)/aunts(s)
[ ] spouse/significant other
[ ] children

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Treatment history:

[ ] outpatient (age[s]_________________)
[ ] impatient (age[s]_________________)
[ ] 12-step program (age[s]___________)
[ ] stopped on own (age[s] ___________)
[ ] other (age[s] ___________________)
describe: _______________________

Substances used: (complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol	__________	__________	_______	_________	_______
[ ] amphetamines/speed	__________	__________	_______	_________	_______
[ ] barbiturates/downers	__________	__________	_______	_________	_______
[ ] caffeine	__________	__________	_______	_________	_______
[ ] cocaine	__________	__________	_______	_________	_______
[ ] crack cocaine	__________	__________	_______	_________	_______
[ ] hallucinogens (e.g. LSD)	__________	__________	_______	_________	_______
[ ] inhalants (e.g. glue, gas)	__________	__________	_______	_________	_______
[ ] marijuana or hashish	__________	__________	_______	_________	_______
[ ] nicotine/cigarettes	__________	__________	_______	_________	_______
[ ] PCP	__________	__________	_______	_________	_______
[ ] prescription________	__________	__________	_______	_________	_______
[ ] other _____________	__________	__________	_______	_________	_______

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose(s) [ ] loss of control amount used [ ] relationship conflicts
[ ] other____

Client Name: ________________________ Client ID#:__________________ Client SS#__________________ Date: ____________

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent client)

Problems during mother's pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:
[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications ______
____
birth weight___lbs___oz.

Infancy:
[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:
[ ] chickenpox (age____)
[ ] German measles (age____)
[ ] Red measles (age____)
[ ] rheumatic fever (age____)
[ ] whooping cough (age____)
[ ] scarlet fever (age_____)
[ ] autism
[ ] ear infections
[ ] lead poisoning (age___)
[ ] mumps (age___)
[ ] diphtheria (age____)
[ ] poliomyelitis (age___)
[ ] pneumonia (age___)
[ ] tuberculosis (age___)
[ ] mental retardation (age____)
[ ] asthma
[ ] allergies to____
[ ] significant injuries____
[ ] chronic, serious health problems____
____

Delayed developmental milestones (check only those milestones that did not occur at expected age):
[ ] sitting [ ] standing [ ] rolling over [ ] controlling bowels [ ] sleeping alone [ ] dressing self [ ] walking [ ] engaging peers [ ] feeding self
[ ] tolerating separation [ ] speaking words [ ] speaking sentences [ ] playing cooperatively [ ] riding tricycle [ ] riding bicycle [ ] controlling bladder
[ ] other ______________________________

Emotional/behavior problems (check all that apply):
[ ] drug use [ ] repeats words of others [ ] distrustful [ ] alcohol abuse [ ] not trustworthy [ ] extreme worrier [ ] chronic lying [ ] hostile/angry mood
[ ] self-injurious acts [ ] stealing [ ] indecisive [ ] impulsive [ ] violent temper [ ] immature [ ] easily distracted [ ] fire setting [ ] bizarre behavior
[ ] poor concentration [ ] hyperactive [ ] self-injurious threats [ ] often sad [ ] animal cruelty [ ] frequently tearful [ ] breaks things [ ] assaults others
[ ] frequently daydreams [ ] disobedient [ ] lack of attachment [ ] other ___________________________

Social interaction (check all that apply):
[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other ____________________

Intellectual/academic functioning (check all that apply):
[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation
Current or highest education level____

Describe any other developmental problems or issues:____
____

SOCIO-ECONOMIC HISTORY (check all that apply for client)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Employment:
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled:____________________

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finance

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-use based friends
[ ] no friends
[ ] distant from family of origin

Military history:
[ ] never in military
[ ] served in military-no incident
[ ] served in military-**with** incident
____

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison_______time(s)
total time served:________
describe last legal difficulty:____

Sexual history:
[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience _____
[ ] age first pregnancy/fatherhood ____
[ ] history of promiscuity age ___ to ___
[ ] history of unsafe sex age ___ to ___
Additional information: ____

Cultural/spiritual/recreational history:
cultural identity (e.g. ethnicity, religion):____
____
describe any cultural issues that contribute to current problem:_______________________
____

currently active in community/recreational activities:	Yes [ ]	No [ ]
formerly active in community/recreational activities	Yes [ ]	No [ ]
currently engage in hobbies	Yes [ ]	No [ ]
currently participate in spiritual activities?	Yes [ ]	No [ ]

If answered "yes" to any of above, describe: _____________________________________
____
____
____

Client Name: ______________________ Client ID#:__________________ Client SS#__________________ Date: _________________

SOURCES OF DATA PROVIDED ABOVE: [ ] Client self-report for all [ ] A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify)_____________________

Family History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify)_____________________

Developmental History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify)______________________________

Emotional/Psychiatric History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify)_______________________

Medical/Substance Use History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify)_____________________

Socioeconomic History
[ ] client self-report
[ ] client's parent/guardian
[ ] other (specify)_______________________________