Patient name _____ Patient ID# _____ Patient SS# _____ Date _____ Page __

# 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-to-day 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 | [ ] | [ ] | [ ] | [ ] | circumstantial symptoms | [ ] | [ ] | [ ] | [ ] | 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 _____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

| Prior provider name | City | State | Phone | Diagnosis | Intervention/Modality | Beneficial? |
|---|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |

**[ ] [ ] 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 a psychiatric, emotional, or substance use disorder?** If yes,
No Yes who/why (list all):_____

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____ Page __

**[ ] [ ] 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
[ ] mother involved with someone
[ ] father involved with someone
[ ] 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 toward 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 a 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 patient's household:**

| Name | Age | Sex | Relationship to patient |
|---|---|---|---|
| _____ | ____ | ____ | _____ |
| _____ | ____ | ____ | _____ |
| _____ | ____ | ____ | _____ |

**List children <u>not</u> living in same household as patient:**

| | | | |
|---|---|---|---|
| _____ | ____ | ____ | _____ |
| _____ | ____ | ____ | _____ |
| _____ | ____ | ____ | _____ |

Frequency of visitation of above: _____

**Describe any past or current significant issues in <u>intimate</u> relationships:** _____
_____
_____
_____

**Describe any past or current significant issues in other <u>immediate family</u> relationships:** _____
_____
_____
_____

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____ Page __

## MEDICAL HISTORY (check all that apply for patient)

**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 chronic or serious health problems _____

_____

**Describe any serious hospitalization or accidents:**
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____

## SUBSTANCE USE HISTORY (check all that apply for patient)

**Family alcohol/drug abuse history:**

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

**Substance use status:**

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

**Substances used:**
**(complete all that apply)**

| | Current Use | | | |
|---|---|---|---|---|
| | **First use age** | **Last use age** | **(Yes/No)** | **Frequency** | **Amount** |
| [ ] alcohol | | | | | |
| [ ] amphetamines/speed | | | | | |
| [ ] barbiturates/owners | | | | | |
| [ ] caffeine | | | | | |
| [ ] cocaine | | | | | |
| [ ] crack cocaine | | | | | |
| [ ] hallucinogens (e.g., LSD) | | | | | |
| [ ] inhalants (e.g., glue, gas) | | | | | |
| [ ] marijuana or hashish | | | | | |
| [ ] nicotine/cigarettes | | | | | |
| [ ] PCP | | | | | |
| [ ] prescription_____ | | | | | |
| [ ] other_____ | | | | | |

**Treatment history:**

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____
describe:_____

**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 [ ] loss of control amount used [ ] relationship conflicts
[ ] other _____

## ABUSE HISTORY (has client been victim of any type of abuse?):

Physical abuse Yes No Emotional Abuse Yes No Sexual Abuse Yes No
Domestic Violence Yes No Abandonment Yes No Neglect Yes No

Age(s) at time of abuse: _____ Treatment received: _____

Who was perpetrator? _____

Reported to Authorities? _____ Finding/disposition: _____

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____ Page __

Did client witness any types of abuse listed above: Yes No

If yes, which type of abuse? _____

Who was the victim? _____ Who was the perpetrator? _____

Has client been the perpetrator of any abuse? Yes No Who was the victim? _____

If yes, which type of abuse? _____

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

**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
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
_____
[ ] lead poising (age _____)
[ ] mumps (age _____)
[ ] diphtheria (age _____)
[ ] poliomyelitis (age _____)
[ ] pneumonia (age _____)
[ ] tuberculosis (age _____)
[ ] mental retardation
[ ] asthma

**Delayed developmental milestones** (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other _____
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

**Emotional / behavior problems** (check all that apply):

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

**Living situation:**

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

**Social support system:**

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

**Military history:**

**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: _____

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____ Page __

**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 finances

[ ] 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: _____

_____

**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: _____

## Spiritual History:

Do you believe in God? Yes No Do you believe in Jesus Christ? Yes No

Do you have a religious affiliation with which you are active? Yes No

Do you feel you have a personal relationship with Jesus Christ? Yes No

Do you believe that the Bible is God's word to mankind and contains truth for your life? Yes No

How does your faith help you to cope with life's problems? _____

What spiritual disciplines do you practice and how much time do you spend (i.e. prayer, Bible reading, Bible study, worship etc.)?

Please describe any difficulties you are having concerning your faith _____

## Emergency Contact:

Who do you want contacted in case of an emergency? (Include name, phone number and relationship.)

## Goals for Counseling:

What three things would you like to change by participating in counseling?

1. _____

2. _____

3. _____

How long do you think it will take to make these changes? _____

What do you think it will require on your part to make these changes? _____

How will you know when you have accomplished your goals for counseling? _____

What else do you think is important for your counselor to know about you? _____

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

| **Presenting Problems/Symptoms** | **Family History** | **Developmental History** |
|---|---|---|
| [ ] patient self-report | [ ] patient self-report | [ ] patient self-report |
| [ ] patient's parent/guardian | [ ] patient's parent/guardian | [ ] patient's parent/guardian |
| [ ] other (specify) _____ | [ ] other (specify) _____ | [ ] other (specify) _____ |
| **Emotional/Psychiatric History** | **Medical/Substance Use History** | **Socioeconomic History** |
| [ ] patient self-report | [ ] patient self-report | [ ] patient self-report |
| [ ] patient's parent/guardian | [ ] patient's parent/guardian | [ ] patient's parent/guardian |
| [ ] other (specify) _____ | [ ] other (specify) _____ | [ ] other (specify) _____ |