BIOPSYCHOSOCIAL – ADULT

Todays' Date _____	Name _____	Date of Birth _____

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 days, 1-6 months, 1-5 years, 5+ years
3. Rate the intensity of the problem 1 - 5, (1 being mild and 5 being severe) _____
4. How is the problem interfering with your day-to-day functioning? _____
5. What are your current goals for therapy? _____

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

☐ Sadness	☐ Hopeless/Helpless	☐ Sleeping too much	☐ Fatigue/no energy
☐ No Motivation	☐ Lack of interest	☐ Thoughts of dying	☐ Guilt
☐ Not hungry	☐ Prefer being alone	☐ Irritable/angry	☐ Can't sleep
☐ No need for sleep	☐ Talk too fast	☐ Impulsive	☐ Can't concentrate
☐ Suspicious	☐ Hearing things	☐ Seeing things	☐ Have special powers
☐ People out to get me	☐ Feeling nervous	☐ Fearful	☐ Panic attacks
☐ Easily startled	☐ Avoidance	☐ Recurring nightmares	☐ Feel worthless
☐ Too much energy	☐ People watching me	☐ Can't be in crowds	☐ Restless

7. Do you now or have you ever contemplated suicide? _____
8. Are you a survivor of trauma? _____
9. Are you pregnant now? If yes, when are you due? _____
10. Are you at risk for HIV/AIDS/Sexually Transmitted Diseases? _____
11. Please list all allergies to medications or food: _____
12. Has your physical health kept you from participating in activities? _____

TOBACCO

	YES	NO	NA
1. Have you ever used any form of tobacco (cigarettes, snuff, etc.)? *IF NO, SKIP TO NEXT SECTION*	☐	☐	☐
2. Are you a former tobacco user?	☐	☐	☐
3. Have you ever been involved in a program to help you quit using tobacco in the past 30 days?	☐	☐	☐

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

SUBSTANCE USE / ADDICTION

	YES	NO	NA
1. Would you or someone you know say that you are having a problem with alcohol?	☐	☐	☐
2. Would you or someone you know say that you are having a problem with pills or illegal drugs?	☐	☐	☐
3. Would you or someone you know say that you are having a problem with other addictions, ie. Gambling, pornography or shopping?	☐	☐	☐

PERSONAL, FAMILY & RELATIONSHIPS

1. Who is in your family? (parents, siblings, children): _____
   _____
2. Has there been any significant person or family member to leave your life in the past 90 days? _____

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

5. Are there any problems in your family now? _____
6. Were there any problems with your family in the past? _____
7. Are there any problems in your support system now? _____
8. What is your marital status now? _____

	YES	NO	NA
9. Have you ever had problems with marriage/relationships?	☐	☐	☐
10. Do you have any close friends?	☐	☐	☐
11. Do you have problems with friendships?	☐	☐	☐
12. Do you get along well with others?	☐	☐	☐

LEGAL

	YES	NO	NA
1. Have you ever been arrested?	☐	☐	☐
2. Have you been arrested in the past year?	☐	☐	☐
3. Were you ever sentenced for a crime?	☐	☐	☐

4. What were you arrested for? _____
5. If you were ever on parole, what is the name of your probation officer? _____

WORK

1. Have you ever served in the military? _____
2. Are you retired? If so, what work did you do in the past? _____
3. What is your work history like? Good, Poor, Sporadic, Other _____