

BIOPSYCHOSOCIAL HISTORY

Name: _____ **Today's Date:** _____ **DOB:** _____

PRESENTING PROBLEMS

What brings you into therapy today? _____

When did the problem arise? _____

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	binging/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	laxative/diuretic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elimination Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	paranoid ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	self mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	medical conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	conduct problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										

EMOTIONAL/PSYCHIATRIC HISTORY

Prior suicide attempts?

No Yes If yes, when? _____

Circumstances that led to the attempt: _____

Current suicidal thoughts?

No Yes If yes, describe: _____

Prior outpatient psychotherapy?

No Yes If yes, on _____ occasions. Longest treatment by _____ for _____ sessions from ____/____ to ____/____

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 ____/____

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, who/why (list all): _____

No Yes _____

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 _____

Name _____

Date _____

FAMILY HISTORY

Family of Origin

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
your age at mothers death _____
- father deceased for ___ years
your age 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 other
- witnessed 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 relationships
- 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 your household:

Name	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children not living in same household as you:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Frequency of visitation of above: _____

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 you)

Describe your 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 and reason):

List any known allergies: _____

Is there a history of any of the following in the family:

- tuberculosis
- birth defects
- emotional problems
- thyroid problems
- cancer
- mental retardation
- other chronic or serious health problems _____
- heart disease
- high blood pressure
- drug abuse
- alcoholism
- diabetes
- Alzheimer's disease/ dementia
- stroke

Name _____

Date _____

SUBSTANCE USE HISTORY (check all that apply for you)

Family alcohol/drug abuse history:

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

Substances used:

(complete all that apply)	First usage	Last usage	Current use (Yes/No)	Frequency	Amount
<input type="checkbox"/> alcohol	_____	_____	_____	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____	_____
<input type="checkbox"/> barbiturates/downers	_____	_____	_____	_____	_____
<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____
<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> hallucinogens (LSD)	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (glue, gas)	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana or hashish	_____	_____	_____	_____	_____
<input type="checkbox"/> nicotine/cigarettes	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____	_____
<input type="checkbox"/> prescription _____	_____	_____	_____	_____	_____
<input type="checkbox"/> other _____	_____	_____	_____	_____	_____

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) _____)
- inpatient (age(s) _____)
- 12 step program (age(s) _____)
- stopped on own (age(s) _____)
- 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 loss of control amount used relationship conflicts
- other _____

SOCIO ECONOMIC HISTORY (check all that apply for you)

Living situation:

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous
- problems with living companions

Social support system:

- supportive network
- few friends
- substance us based friendships
- no friends
- distant from family of origin

Sexual history:

- heterosexual orientation currently sexually dissatisfied
- homosexual orientation currently sexually satisfied
- bisexual orientation currently sexually active
- sexual problems _____

Employment:

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- supervisor conflicts
- unstable work history
- disabled: _____

Financial situation:

- no current financial problems
- large amounts of debt
- poverty or below poverty line
- impulsive spending
- relationship conflicts over spending

Legal history:

- no legal problems
- now on parole/ probation
- arrest(s) not substance related
- court ordered this treatment
- jail/prison _____ time (s)

What is your field of employment? _____

Name of Employer? _____

Highest level of education completed? GED High School Associates Degree Some College Four years College Masters Degree Ph. D. (Circle One)

Where did you attend school and what did you study? _____

Cultural/spiritual/recreational history:

Cultural identity (e.g. ethnicity, religion) _____

Describe any cultural issues that contribute to current problems: _____

Are you currently active in community/recreational activities? _____

What are your hobbies? _____

Do you exercise? Yes No Explain: _____

Thank You