Name:

"That all may have life, life in all its fullness." - John 10:10

BIOPSYCHOSOCIAL INTAKE FORM/ASSESSMENT

Client Name:____ **Date:**_________________

Client Age and Date of Birth:_________________________________ **Gender:** ☐**Male** ☐**Female**

Primary Language Spoken:____

Email Address:____

Name the presenting problem(s) for which you/your child are seeking help:

1.____

2.____

3.____

What are your/your child's treatment goals?

____

____

____

Presenting Symptom Checklist (check box for any symptoms present) which may cause distress or impairment in Social, Occupational, or other important areas of functioning:

☐Depressed mood ☐Racing thoughts ☐Concentration/Forgetfulness ☐Impulsivity

☐Change in appetite ☐Excessive Guilt ☐Increased/Decreased libido ☐Angry Outbursts

☐Phobias ☐Fatigue ☐Increased Risky Behavior ☐Crying Spells

☐Excessive Worry ☐Excessive Energy ☐Increased Irritability ☐Low Self-Esteem

☐Cutting ☐Suspiciousness ☐Poor Social Interactions ☐Suspiciousness

☐Delusions (e.g.. Grandiose, etc.) ☐Loss of Interest (in previously enjoyed activities) ☐Sleep pattern disturbance (Hypersomnia/Insomnia) ☐Audio/Visual Hallucinations

☐Hypervigilance ☐Flash Backs ☐Obsessions/Compulsions ☐Avoidance

☐Unintentional Weight Gain/Loss ☐Anxiety/Panic Attacks

☐Verbal/Physical/Aggressive Behavior ☐Other: _______________________________________

Name:

Are there any biological, psychological, and/or social concerns that can be attributed to his/her/your condition?
☐Yes ☐No If yes, please explain:

____

____

____

Suicide/Homicide Risk Assessment:

Do you feel or have thoughts that you would like to harm yourself or someone else? ☐Yes ☐No

Have you thought about how you would kill yourself or someone else?_____________________________

Is the method you would use readily available?____

Have you planned a time for this?____

Is there anything that would stop you from killing yourself or someone else?________________________

Have you tried to kill or harm yourself or anyone else before?_____________________________________

If yes, please explain.____

Have you ever had feelings or thoughts that you didn't want to live? ☐Yes ☐No If YES, please answer the following. If NO, please skip to the next section.

Do you feel hopeless and/or worthless?____

Do you currently feel that you don't want to live? ☐Yes ☐No

How often do you have these thoughts?____

When was the last time you had thoughts of dying?____

Has anything happened recently to make you feel that way?_______________________________________

On a scale of 1 to 10 (10 being the strongest), how strong is your desire to kill yourself currently?______

Would anything make it better?____

Medical History:

Allergies:____

Current or over-the-counter medications or supplements:

____

Name:

Current Medical Problems:

____

____

Past medical problems, non-psychiatric hospitalizations, or surgeries:

____

____

Date and place of last physical exam:____

Personal and Family Medical History:

Thyroid Disease	Kidney Disease	Cancer (type)________________
Anemia	Diabetes	Fibromyalgia
Liver Disease	Asthma/Respiratory Problems	Heart Disease
Chronic Fatigue	Stomach/Intestinal Problems	Epilepsy or Seizures
Chronic Pain	High Cholesterol	High Blood Pressure
Head Trauma	Liver Problems	

Other (Specify):____

Condition: **Which Family Member:**

____

____

____

Is there any additional personal or family medical history? ☐Yes ☐No If yes, please explain:

____

____

When your mother was pregnant with you, (or you were pregnant with your child), were there any complications related to this pregnancy? (Pre-, during and/or Peri-natal) ☐Yes ☐No If yes, please explain:

____

____

Are you (or your child) current with all immunizations? ☐Yes ☐No If no, please explain:

____

Name:

Past Psychiatric History:

Outpatient treatment ? ☐Yes ☐No If yes, please describe below when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization? ☐Yes ☐No If yes, please describe for what reason, when, and where.

Reason	Date Hospitalized	Where

Past psychiatric medications: IF you have ever taken any of the following medications, please indicate the dates, dosages, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants:
Prozac (fluoxetine) Zoloft (sertraline) Luvox (fluvoxamine)
Paxil (paroxetine) Celexa (citralopram) Lexapro (escitalopram)
Effexor (venlafaxine) Cymbalta (duloxetine) Wellbutrin (bupropion)
Remeron (mirtazapine) Serzone (neazodone) Anafranil (clominpramine)
Pamelor (nortriptyline) Tofranil (imipramine) Elavil (amitriptyline)

Mood Stabilizers:
Tegretol (carbamazepine) Depakote (valproate) Lithium
Lamictal (lamotrigine) Topomax (topiramate)

Antipsychotic/Mood Stabilizer Medications:
Seroquel (quetiapine) Zyprexa (olanzapine) Geodon (ziprasidone)
Abilify (aripiprazole) Clozril (clozapine) Prolixin (tluphenazine) Haldol (haloperidol)
Risperdal (risperidone)

Sedatives/Hypnotics:
Ambien (zolpidem) Sonata (zaleplon) Rozerem (ramelteon)
Restoril (temazepam) Desyrel (trazadone)

ADHD Medications:
Adderall (amphetamine) Concerta (methylphenidate) Ritalin (methylphenidate)
Strattera (atomoxetine)

Name:

Anti-Anxiety Medications:

Xanax (alprazolam)	Ativan (lorazepam)	Klonopin (clonazepam)
Valium (diazepam)	Tranxene (clorazepate)	Buspar (buspirone)

List ALL current medications and how often you take them (If none, write none):

Medication Name	Total Daily Dosage	Estimated Start Date

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for: (Circle)

Bipolar Disorder Depression Anxiety Anger Suicide Schizophrenia
Post-traumatic Stress Disorder Alcohol Abuse Other substance abuse Violence

If yes, who had each problem?

____

____

Has any family member been treated with a psychiatric medication? ☐Yes ☐No
If yes, who was treated, what medications did they take, and how effective was the treatment?

____

____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐Yes ☐No

If yes, for what substances?____

If yes, where were you treated and when?

____

How many days per week do you drink alcohol?____

What is the least number of drinks you will drink in a day?____

Name:

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

____

Have you ever felt you ought to cut down on your drinking or drug use? ☐Yes ☐No

Have people annoyed you by criticizing your drinking or drug use? ☐Yes ☐No

Have you ever felt bad or guilty about your drinking or drug use? ☐Yes ☐No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐Yes ☐No

Do you think you may have a problem with alcohol or drug use? ☐Yes ☐No

Have you used any street drug within the past three months? ☐Yes ☐No

If yes, which ones?____

Have you ever abused prescription medication? ☐Yes ☐No

If yes, which ones?____

Circle if you have ever tried the following:

Methamphetamine	Cocaine	Stimulants (pills)	Heroin	LSD or Hallucinogens
Pain Killers (not as prescribed)	Methadone	Alcohol	Ecstasy	Tranquilizers/sleeping pills

Other:____

How many caffeinated beverages do you drink a day? Coffee________ Sodas________ Tea_________

Tobacco History:

Have you ever smoked cigarettes? ☐Yes ☐No

Currently? ☐Yes ☐No How many packs per day on average?________ In the past? ☐Yes ☐No

How many years did you smoke?_________ When did you quit?_________________________________

Do you smoke pipes or cigars or use chewing tobacco? ☐Yes ☐No In the past? ☐Yes ☐No

What kind?_______________________ How often per day on average? __________ How many years?_____

Family Background and Childhood History:

Were you adopted? ☐Yes ☐No Where did you grow up?_______________________________________

Name:

List your siblings and their ages:____

What is/was your father's occupation?____

What is/was your mother's occupation?____

Did your parents divorce? ☐Yes ☐No If so, how old were you when they divorced?_______________
If your parents divorced, who did you live with?____

Describe your father and your relationship with him.

____

____

Describe your mother and your relationship with her.

____

____

How old were you when you left home?________________

Has anyone in your immediate family died? ☐Yes ☐No

Who, When, and how?____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, verbally, or by neglect? ☐Yes ☐No

Please describe when, where, and by whom, and was this abuse reported/investigated? ☐Yes ☐No

____

____

Have you witnessed domestic violence? ☐Yes ☐No

Education History:

Do you attend school or college? ☐Yes ☐No If so, where do you attend and what grade are you in?

____

What is your highest level or degree attained?____

Name:

Occupational History:

Are you currently: ☐Working? ☐Student? ☐Unemployed? ☐Disabled? ☐Retired?

Where do you work?____

How long in and what is your present position?____

Have you ever served in the military? ☐Yes ☐No If so, what branch and when?_______________________
What type of discharge?____

Relationship History and Current Family:

Are you currently: ☐Married? ☐Partnered? ☐Divorced? ☐Single? ☐Widowed?

How long?_______________________

If in a relationship, what is your spouse or significant other's occupation?_______________________________

Describe your relationship with your spouse or significant other:

____

____

Have you had any prior marriages? ☐Yes ☐No If so, how many?_________ How long?________________

Do you have any children? ☐Yes ☐No If yes, list ages and gender:

____

Describe your relationship with your children:

____

____

List everyone who currently lives with you:

____

____

Name:

Legal History:

Have you ever been arrested? ☐Yes ☐No Do you have any pending criminal charges? ☐Yes ☐No

If yes, please describe and provide current status:

____

____

Are you currently involved in any lawsuits (custody battle, civil suits, divorce proceedings)? ☐Yes ☐No

If yes, please describe and provide current status:

____

____

Discrimination:

Are you experiencing discrimination in any of these areas?

☐Age ☐Gender ☐Race ☐Sexual Orientation ☐Religion

Explain:

____

____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ☐Yes ☐No

If yes, what is the current level of your involvement?____

Do you find your involvement helpful during time of struggle, or does involvement make things more difficult or stressful for you? ☐Helpful ☐More difficult

Is there anything else you would like us to know?

____

____

____

____

Name:

Mini-Mental Status Exam:

Given: ☐Yes ☐No (See attached)

Clinical Diagnostic Impression:

____

____

____

____

Treatment Recommendations:

____

____

____

____

It has been determined by the undersigned therapist, that these services are medically necessary for the well-being of the client.

____

Client Signature Date

____

Guardian Signature (if applicable) Date

____

Clinician Date