Avers & Biddle Counseling Associates LLC

Biopsychosocial Assessment

Today's date: _____

Name: _____ Date of birth: _____ Age: ____

Social Security #: _____Address: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Address: _____

1. How did you find out about my services?

_____

_____

2. Please describe the main difficulty that has brought you to see me:

_____

_____

3. What would you like to have happen in therapy? What would you like to see change? _____

_____

_____

4. How do you normally cope with stress?

_____

_____

5. What are your strengths?

_____

_____

6. What are your weaknesses?

Client Name: _____

_____

_____

7. Is there anything you would like me to know about your values, culture, or spiritual beliefs?

_____

_____

8. Have you had therapy in the past and if so please describe your experience (what was helpful, what you didn't like, etc.):

_____

_____

_____

Please check each symptom you have experienced in the past or are currently experiencing:

Symptom	**Present**	**Past**	**Symptom**	**Present**	**Past**
Generalized Anxiety			Obsessions/Compulsions		
Depression			Phobias		
Panic Attacks			Suicidal Thoughts		
Sleep Disturbance			Suicide Attempts		
Fatigue/Low Energy			Self-Harm (cutting, burning, etc.)		
Poor Concentration			Poor Appetite/Weight Loss		
Mood Swings			Thoughts of hurting others		
Agitation/Irritability			Physical Violence		
Weight Gain/Overeating			Hearing/Seeing things		
Feeling like I'm being watched			Sexual Dysfunction		
Grief/Loss			Social Isolation		
Hyperactivity			Somatic Complaints		
Excessive Guilt			Dissociative States		
Flashbacks			Nightmares		

Client Name: _____

Medical and Psychiatric History

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
❑ No ❑ Yes If yes, please indicate:

When? From whom? For what?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes,please indicate:
When? From whom? Which medications? For what? With what results?

3. How would you describe your physical health (fair, poor, good, etc)? _____
_____

4. Do you have any significant medical conditions? _____
_____
_____

5. Please list any medications you are currently taking: _____
_____
_____

6. From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____ Address:

_____

May I contact your medical doctor so that he or she can be fully informed and we can coordinate your treatment?
❑ Yes ❑ No

Relationships in Your Family Of Origin

Please describe the following:
1. Your parents' relationship with each other: _____
_____

_____

_____

2. Your relationship with each parent and with any other adults present: _____
_____

_____

Client Name: _____

_____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____
_____

_____

_____

4. Your relationship with your siblings in the past and present: _____
_____

_____

_____

Present relationships

1. Please list all members currently living in the home and your relationship with them (mom, sister, friend, etc):
_____
_____
_____

2. How do you get along with your present spouse or partner? _____
_____

_____

_____

3. How do you get along with your children? _____
_____

_____

_____

4. What relationships are important to you?
_____
_____

Abuse history:

1. Is there any history of physical, emotional or sexual abuse?

---

2. When did this occur?
_____
_____

Client Name: _____

3. Has it been reported? To whom and when?

_____

_____

4. Have you witnessed any family violence?

_____

_____

5. Have you ever abused anyone?

_____

_____

6. Do you feel safe in your current living situation?

_____

_____

Chemical use

1. How many drinks do you have per day that contain caffeine?_____

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever felt the need to have a drink first thing in the morning? ❑ No ❑ Yes

7. How much beer, wine, or hard liquor do you consume each week,on the average? _____

8. Are there times when you drink to unconsciousness,or run out of money as a result of drinking? ❑ No ❑ Yes

9. Have you ever used inhalants (“huffing”), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

_____

Please provide details about your use of these drugs, such as amounts, how often you used them, their effects, etc.:

_____

_____

_____

Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain: _____

_____

_____

2. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain: _____

Client Name: _____

_____

_____

3. Are you currently on probation, parole, or do you have pending legal charges or fines?

_____

_____

_____

4. Are there any other legal involvements I should know about? _____

_____

_____

Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

_____

_____

_____

_____

_____

_____

_____