BIOPSYCHOSOCIAL

Client Name: _____ DOB: _____ Gender: _____ Date Completed: _____

Name of person completing this form and relationship to client: _____

Reason for seeking counseling:

Problems and Symptoms	Past	Present	Not Applicable	Explanation
Change of Appetite	☐	☐	☐	
Bingeing/purging food	☐	☐	☐	
Weight loss/gain	☐	☐	☐	
Insomnia/hypersomia	☐	☐	☐	
Withdrawn	☐	☐	☐	
Depression	☐	☐	☐	
Mood Swings	☐	☐	☐	
Anxiety	☐	☐	☐	
Obsessive Thou	☐	☐	☐	
Compulsive B iors	☐	☐	☐	
Anger Manag t	☐	☐	☐	
Cruelty to An	☐	☐	☐	
Poor Memory	☐	☐	☐	
Proces g Diffi	☐	☐	☐	
Fire s	☐	☐	☐	
Bladde	☐	☐	☐	
Bowel Control	☐	☐	☐	
Aggression	☐	☐	☐	
Lying	☐	☐	☐	
Stealing	☐	☐	☐	
Sexual Acting Out	☐	☐	☐	
Sexual Abuse	☐	☐	☐	
Nightmares/night terrors	☐	☐	☐	
Vivid dreams	☐	☐	☐	
Fears	☐	☐	☐	
Unexplained physical complaints	☐	☐	☐	
Abuse/neglect	☐	☐	☐	
Grief/loss	☐	☐	☐	
Stress	☐	☐	☐	
Flash Backs	☐	☐	☐	
Financial	☐	☐	☐	
Addictive Behavior	☐	☐	☐	
Impulsivity	☐	☐	☐	
Hyperactivity	☐	☐	☐	
Lethargic	☐	☐	☐	
Poor Concentration	☐	☐	☐	
Short Attention Span	☐	☐	☐	
Poor Family Relations	☐	☐	☐	
School Attendance Problems	☐	☐	☐	
Poor Relations with Peers	☐	☐	☐	
Hallucinations/delusions	☐	☐	☐	
Difficulty with Authority	☐	☐	☐	
Spiritual Issues	☐	☐	☐	
Feeling inadequate/Low self worth	☐	☐	☐	
Other	☐	☐	☐	

Mental Health History: (Past out patient services and hospitalizations, include dates)

_____

_____

How did it help? _____

What was your diagnosis (es)? _____

Have you ever experienced suicidal/homicidal ideations? Yes/No Intentions? Yes/No

If yes, please explain: _____

_____

Are you willing to sign a release of information for previous mental health providers? Yes/No

Primary Care Giver is (Circle One): Biological Parent Adoptive Parent Foster Parent Other

Primary Care Giver is (Circle One): Married Single Divorced Widowed Other

Name siblings and ages: _____

_____

Legal Issues: (List any past & present legal issues: i.e., arrests, convictions, etc. include dates)

_____

_____

Abuse His (has client been v tim of any type of abuse?)**:**

Physical ab ☐ Yes ☐ No notional Abuse ☐ Yes ☐ No Sexual Abuse ☐ Yes ☐ No

Domestic V e ☐ Yes ☐ bandonment ☐ Yes ☐ No Neglect ☐ Yes ☐ No

Ag at tim buse Treatment received: _____

Wh rato

Reporte Auth Findi sition: _____

Did client witness any types buse d a e: ☐ ☐

If yes, which type of abuse? _____

Who was the victim? _____ Wh as the etrat

Has client been the perpetrator of a abus es ☐ W as th im?

If yes, which type of abuse? _____

Substance Use History (If you need more space us ck of e)**:**

Substance	Yes	No	Substance	Yes	No	Substa	Yes	No
Alcohol	☐	☐	Pain Pills	☐	☐	Mari a	☐	☐
Tranquilizers	☐	☐	Stimulants	☐	☐	Inh s	☐	
Sleeping Pills	☐	☐	Narcotics	☐	☐	F		
Hallucinogens	☐	☐	Heroin/Meth	☐	☐	Sex		☐
Gambling	☐	☐	Pornography	☐	☐	Tobacco		☐

Drug of preference: _____ How long used? _____ Last used? _____

Treatment program: _____ When? _____ How long? _____ How long clean/sober? _____

Medical History (If you need more space use back of page)**:**

List any major accidents, illnesses, operations with date of occurrence: _____

_____

_____

List date and type of any head injuries or seizures: _____

_____

List current medications and reason prescribed: _____

_____

List any allergies to medications: _____

List any sexually transmitted diseases: _____

Physician:
Is the client currently under a physician's care? _____
Names of Physicians/Specialists who are treating you: _____
_____
_____
_____

Education:
What school are you enrolled in? _____ Highest grade completed: _____
Any difficulty learning to Read: _____ Write: _____ Math: _____
Did you ever repeat a grade? Yes/No For what reason: _____
Favorite subject: _____ Most accomplished subject: _____
Describe any difficulties client is having related to their education: _____
_____

Strengths and Interests:
What do you enjoy doing the most? : _____
What do you do well? : _____

Circle all of the f hat best describe you: Artistic Athletic Organized Smart
Happy Health Fun e around Polite Thoughtful Kind Likes Animals Hard Worker
Completes Wo Musical Loving Strong Funny Confident Creative Mathematical

Social Relation
How frequently d spend w riends? _____
How of do you nd ti th e ded fam _____
What k es u do n you g er? _____
_____
On a scale of 1-10, ing ve fied:
Rate your satisfaction w eer ons s: _____
Rate your satisfaction v exte d fa re nsh _____
Who do you feel is "on your side n li _____
Are there any people in your life you ca talk t your blems _____
Please describe any difficulties you are having friend fami _____
_____

Family History (Please list those family members with a his y of mental ill learning disabilities, mental retardation or addictions) (If you need more space use ba r page)

Parents: _____
_____
Siblings: _____
_____
_____
Maternal Grandparents: _____
_____
Paternal Grandparents: _____
_____
Maternal Aunts and Uncles: _____
_____
Paternal Aunts and Uncles: _____
_____

Developmental History:
Prenatal health issues: _____
_____
Birth Trauma (C-section, birth injuries, complications): _____
_____
Developmental Milestones: Describe any problems with the following:
Attachment/bonding: _____
Motor skills: _____
Toileting: _____
Speech/language: _____
Social Skills: _____
Temperament: _____

Stressors: Please circle all following which the client has experienced in the last year:
Death of a loved one New School New Home Loss of Pet Serious Illness Care Givers Absence
Dept of Child[illegible] Families Involvement Divorce New Sibling Trauma Natural Disaster
Other: _____

Wellness
How many [illegible]p servin[illegible] f[illegible] fruits an[illegible]getables do you eat daily? _____
H[illegible]v much [illegible]ine d[illegible] co[illegible]ne daily [illegible]ps of coffee/tea, 12 oz sodas etc.)_____
I[illegible] man[illegible] up s[illegible]gs of[illegible]ned foo[illegible]u eat daily? (White bread, pasta, rice, cookies, cakes, cra[illegible] _____
How much fa[illegible]d d[illegible] 1-[illegible]ail[illegible] l[illegible]y 1-3 Monthly None
Energy level[illegible] lethargic[illegible] [illegible]erage[illegible]high hyperactive
How would you rate your[illegible]ent h[illegible]n: [illegible]or[illegible]rai[illegible] goo[illegible][illegible]nt
List any food allergies yo[illegible]ve: _____
How would you rate your weigh[illegible]eight/[illegible] ratio[illegible] fa[illegible] g[illegible] excellent
On a scale of 1-10, 10 being very satisfi[illegible]w sati[illegible] are [illegible]ith y[illegible]ody [illegible]ge: _____
Please describe any difficulties you are ha[illegible]ng wit[illegible]alth, [illegible]ima[illegible]
_____
_____
Describe your exercise routine (what you do, how often you do it) _____
_____
_____

Spiritual History:
Do you believe in God? Yes/No
Do you have a religious affiliation with which you are active? Yes/No
Do you use any particular religious writings (Bible, Tanakh, Qur'an etc) to find truth for your life? Yes/No
How does your faith help you to cope with life's problems? _____
_____
_____
_____
Please describe any difficulties you are having concerning your faith _____
_____
_____

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 els[illegible]you think is impor[illegible]t for your counselor to know about you? _____

Emergency Contact:
Who do you want contacted in case of an emergency? (Include name, phone number a[illegible]nship.)
_____
_____

Client Signature: _____ Date: _____

Primary Caregiver's signature: _____ Date _____