

Patient Name _____
 Last Name Name Initial

Date _____
 DD/MM/YYYY

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting Problems	Duration	Additional Information
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 (Mod)**= 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	Mod	Severe		None	Mild	Mod	Severe
depressed mood	[]	[]	[]	[]	physical trauma victim	[]	[]	[]	[]
appetite disturbance	[]	[]	[]	[]	paranoid ideation	[]	[]	[]	[]
sleep disturbance	[]	[]	[]	[]	delusions	[]	[]	[]	[]
elimination disturbance	[]	[]	[]	[]	hallucinations	[]	[]	[]	[]
fatigue/low energy	[]	[]	[]	[]	aggressive behaviors	[]	[]	[]	[]
poor concentration	[]	[]	[]	[]	conduct problems	[]	[]	[]	[]
poor grooming	[]	[]	[]	[]	oppositional behavior	[]	[]	[]	[]
mood swings	[]	[]	[]	[]	sexual dysfunction	[]	[]	[]	[]
agitation	[]	[]	[]	[]	grief	[]	[]	[]	[]
irritability	[]	[]	[]	[]	hopelessness	[]	[]	[]	[]
generalized anxiety	[]	[]	[]	[]	social isolation	[]	[]	[]	[]
panic attacks	[]	[]	[]	[]	worthlessness	[]	[]	[]	[]
phobias	[]	[]	[]	[]	guilt	[]	[]	[]	[]
obsessions/compulsions	[]	[]	[]	[]	elevated mood	[]	[]	[]	[]
bingeing/purging	[]	[]	[]	[]	hyperactivity	[]	[]	[]	[]
laxative/diuretic abuse	[]	[]	[]	[]	dissociative states	[]	[]	[]	[]
anorexia	[]	[]	[]	[]	somatic complaints	[]	[]	[]	[]
sexual trauma perpetrator	[]	[]	[]	[]	self-mutilation	[]	[]	[]	[]
emotional trauma perpetrator	[]	[]	[]	[]	significant weight gain/loss	[]	[]	[]	[]
sexual trauma victim	[]	[]	[]	[]	associated medical condition	[]	[]	[]	[]
physical trauma perpetrator	[]	[]	[]	[]	substance use	[]	[]	[]	[]
emotional trauma victim	[]	[]	[]	[]	loose associations	[]	[]	[]	[]
	[]	[]	[]	[]	other: _____	[]	[]	[]	[]

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy? NO YES If yes, how many occasions? _____

Longest treatment by _____ for _____ sessions from ____/____/____ to ____/____/____
Provider Name Month/Year Month/Year

Prior Provider Name	City/State	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has any family member had outpatient psychotherapy? NO YES

If yes, who/why? (list all) _____

Prior Provider Name	City/State	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?

NO YES If yes, how many occasions? _____

Longest treatment by _____ for _____ sessions from ____/____/____ to ____/____/____
Provider Name Month/Year Month/Year

Prior Provider Name	City/State	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? NO YES If yes, who/why? (list all)

Prior or current psychotropic medication usage? NO YES If yes:

Medication	Dosage	Frequency	Start/End Date	Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has any family member used psychotropic medications? NO YES

If yes, who/why? (list all) _____

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FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[]	[]	[]
father	[]	[]	[]
stepmother	[]	[]	[]
stepfather	[]	[]	[]
brother(s)	[]	[]	[]
sister(s)	[]	[]	[]
other: (specify)	[]	[]	[]

Parents current marital status:

- [] married to each other
- [] separated for ____ year(s)
- [] divorced for ____ year(s)
- [] mother remarried ____ time(s)
- [] father remarried ____ time(s)
- [] mother involved with someone
- [] father involved with someone
- [] mother deceased for ____ year(s)
age of patient at mother's death _____
- [] father deceased for ____ year(s)
age of patient at father's death _____

Describe Parents:

Father

Name: _____

Occupation: _____

Education: _____

General Health: _____

Mother

Describe childhood family experience:

- [] outstanding home environment
- [] normal home environment
- [] chaotic home environment
- [] witnessed physical/verbal/sexual abuse toward others
- [] experienced physical/verbal/sexual abuse from others

Special circumstances in childhood: _____

Describe any past or current significant issues in intimate relationships: _____

Describe any past or current significant issues on other immidate family relationships:

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IMMEDIATE FAMILY (check if all that apply to the patient. If not, leave in blank)

Marital Status:

- single, never married
- engaged ____ year(s)
- married for ____ year(s)
- divorced for ____ year(s)
- separated for ____ year(s)

Intimate Relationship:

- never been in a serious relationship
- not currently in relationship
- currently in a serious relationship

Relationship satisfaction:

- divorce in process ____ year(s)
- live-in for ____ years
- ____ prior marriages (self)
- ____ prior marriages (partner)
- very satisfied with relationship
- satisfied with relationship
- somewhat satisfied with relationship
- dissatisfied with relationship
- very dissatisfied with relationship

List all persons currently living in patient's household:

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Relationship to patient</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children not living in same household as patient:

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Relationship to patient</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

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MEDICAL HISTORY

Describe current physical health: [] GOOD [] FAIR [] POOR

Name of Primary Care Physician: _____ **Phone:** _____

Name of Psychiatrist: _____ **Phone:** _____

List any medications currently being taken (give dosage & reason)

List any known allergies: _____

List any abnormal lab test results:

Date _____ Result _____
Date _____ Result _____

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

- [] tuberculosis [] heart disease [] cancer
- [] birth defects [] high blood pressure [] intellectual disability
- [] emotional problems [] alcoholism [] thyroid problems
- [] behavior problems [] drug abuse [] diabetes
- [] Alzheimer/dementia [] stroke [] other chronic or serious health problems

Describe any serious hospitalization or accidents:

Date: _____ Age _____ Reason : _____
Date: _____ Age _____ Reason : _____
Date: _____ Age _____ Reason : _____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

- [] father [] stepparent/live-in
- [] mother [] uncle(s)/aunt(s)
- [] grandparent(s) [] spouse/significant other
- [] sibling(s) [] children
- [] other

Substance use status:

- [] no history of abuse
- [] active abuse
- [] early full remission
- [] early partial remission
- [] sustained full remission
- [] sustained partial remission

Consequences of substance abuse (check all that apply):

- [] hangovers [] withdrawal symptoms [] sleep disturbance [] job loss
- [] seizures [] medical conditions [] assaults [] arrests
- [] blackouts [] tolerance changes [] suicidal impulse
- [] overdose [] loss of control amount used [] relationship conflicts
- [] other _____ [] binges

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Continue...

SUBSTANCE USE HISTORY (check all that apply for patient)

Current Use

	First use age	Last use age	(Yes/No)	Frequency	Amount
<input type="checkbox"/> amphetamines/speed					
<input type="checkbox"/> barbiturates/owners					
<input type="checkbox"/> caffeine					
<input type="checkbox"/> cocaine					
<input type="checkbox"/> crack cocaine					
<input type="checkbox"/> hallucinogens (e.g., LSD)					
<input type="checkbox"/> inhalants (e.g., 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 _____					

Treatment History:

- outpatient (age[s] _____)
- inpatient (age[s] _____)
- 12-step program (age[s] _____)
- stopped on own (age[s] _____)
- other (age[s] _____)

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:

- none
- high blood pressure
- kidney infection
- German measles
- emotional stress
- bleeding
- alcohol use
- drug use
- cigarette use
- other _____

Birth:

- normal delivery
- difficult delivery
- cesarean delivery
- complications _____
- birth weight
lbs _____ oz. _____

Infancy:

- feeding problems
- sleep problems
- toilet training problems

Childhood health:

- chickenpox (age _____)
- German measles (age _____)
- red measles (age _____)
- rheumatic fever (age _____)
- whooping cough (age _____)
- scarlet fever (age _____)
- ear infections
- asthma
- allergies to _____
- significant injuries _____
- chronic, serious health problems
- autism
- intellectual disability

Continue...

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Delayed developmental milestones

Emotional / behavior problems (check all that apply)

(check only those milestones that

did not occur at expected age):

- sitting
- rolling over
- standing
- walking
- feeding self
- speaking words
- speaking sentences
- controlling bladder
- other
- controlling bowels
- sleeping alone
- dressing self
- engaging peers
- tolerating separation
- playing cooperatively
- riding tricycle
- riding bicycle

- drug use
- alcohol abuse
- chronic lying
- stealing
- violent temper
- fire-setting
- hyperactive
- animal cruelty
- assaults others
- disobedient
- distrustful
- extreme worrier
- self-injurious acts
- impulsive
- repeats words of others
- not trustworthy
- hostile/angry mood
- indecisive
- immature
- bizarre behavior
- self-injurious threats
- frequently tearful
- frequently daydreams
- lack of attachment
- easily distracted
- poor concentration
- often sad
- breaks things
- other _____

Social interaction (check all that apply)

Intellectual / academic functioning (check all that apply):

- normal social interaction
- isolates self
- very shy
- alienates self
- inappropriate sex play
- dominates others
- associates with acting-out peers
- other

- normal intelligence
- high intelligence
- learning problems
- authority conflicts
- attention problems
- underachieving
- Current or highest education level _____

- Intellectual Disability**
- mild
 - moderate
 - severe

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Describe any other developmental problems or issues:

Living situation:

Social support system:

Sexual history:

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

- supportive network
- few friends
- substance-use-based frier
- no friends
- distant from family of origin

- heterosexual orientation
- homosexual orientation
- bisexual orientation
- currently sexually active
- currently sexually satisfied
- currently sexually dissatisfied
- age first sex experience
- age first pregnancy/fatherhood
- history of promiscuity age
- history of unsafe sex age

Additional information:

Employment:

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

Financial situation:

- no current financial problems
- large indebtedness
- poverty or below-poverty income
- impulsive spending
- relationship conflicts over finances

Military Service:

- never in military
- served in military - no incident
- served in military - **with** incident

Legal history:

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

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion): _____

describe any cultural issues that contribute to current problem: _____

currently active in community/recreational activities? Yes No

formerly active in community/recreational activities? Yes No

currently engage in hobbies? Yes No

currently participate in spiritual activities? Yes No

if answered "yes" to any of above, describe: _____

SOURCES OF DATA PROVIDED ABOVE:

- Patient self-report for all
- A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms

- patient self-report
- patient's parent/guardian
- other (specify)

Family History

- patient self-report
- patient's parent/guardian
- other (specify)

Developmental History

- patient self-report
- patient's parent/guardian
- other (specify)

Emotional/Psychiatric History

- patient self-report
- patient's parent/guardian
- other (specify)

Medical/Substance Use

- patient self-report
- patient's parent/guardian
- other (specify)

Socioeconomic History

- patient self-report
- patient's parent/guardian
- other (specify)