Bio-Psycho-Social Assessment-Adult

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NPI # 1487828554

I. Client and Home

Name: _____ Date of Birth_____ Age _____
Social Security Number:_____ _____
Name and d.o.b. of primary insured (if different) _____
Address _____
_____ ____
Phone Number(s)_____
_____

Emergency Contacts and Phone Numbers _____
_____
EAP? Circle one: yes or no. Authorization Number _____
Health Insurance _____Subscriber Number _____
Name of Primary Insured_____ d.o.b._____
Address of Primary Insured (if different than your own) _____
Authorization Number (if required) _____
Phone number for Mental Health (found on back of card) _____

SECTION (A)

Please fill in the following table: Who lives in the home?

Name	Relationship to the Client	Date of Birth	Highest level of Education

II. Strengths Assessment – Client and Family

What are your strengths? _____
_____
_____
What are the family's (those who live in the home) strengths? _____
_____
Is there extended family support? Describe: _____
_____
Describe the importance of spirituality (relationship with Creator) and/ or religion (institution) in your life and family (if any): _____
_____

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Describe any cultural/ ethnic factors which may impact on _____
treatment:_____

III. Presenting Problem

Please state why you are seeking mental health services. (i.e., Why are you here?) _____

What areas of your life is this problem affecting?_____

How long have these issues been present (weeks, months, years, whole life)? _____

Have you ever received mental health services anywhere before? _____
If so, where (include dates and length of service)? _____

Was it helpful?_____

Are there any other agencies involved with the client at this time? _____

Are there any community support groups (church, sports, boy scouts, youth group, Methodist Women's Association, Alcoholics Anonymous, Native gatherings, Wiccan circles, etc.) _____

Please list those events, situations, and problems that are causing stress for the client and his/ her family.

How have you tried to resolve the problem prior to coming here?_____

Why are you seeking help at this particular time?_____

What has changed (if applicable) that the client (or client's family) needs help?_____

Suicidal Ideation? (If so, plan, seriousness?) _____

Homicidal or Suicidal thoughts? _____

History of homicide/ suicide attempts? _____

Have you ever been hospitalized before for mental health reasons?_____

_____

IV. Family or Marital History

Marital Status?_____

Describe the relationship between client and others in the house: _____

_____

_____

_____

If the client has a significant other, please answer the rest of the questions in this section:

Describe the relationship with your spouse or significant other. _____

_____

_____

The strengths of this relationship: _____

_____

Needs or Concerns in this relationship:_____

_____

History of Domestic Violence (verbal or physical) in any of your relationships? _____

_____

Communication Problems (past and present)? _____

_____

How many times have you separated and gotten back together with your current partner?

_____

Briefly describe the average argument you have with your current partner: _____

_____

V. Socio-Economic Data: Without telling me how much you make, please pick one of the following options that may describe your current financial situation. (Put an "X" at the appropriate choice.)

___ 1. I am not worried about my bills. I have more than enough to meet my needs each month.
___ 2. I am not worried about the bills. However, paying for everything is a little tight.
___ 3. I am barely scraping by. My family has to be creative in order make sure we have the basics.
___ 4. Our basic needs are barely met. I am thinking about declaring bankruptcy. I feel like we will have to do "macaroni and cheese" every night for a while, so that we have food on the table.
___ 5. I am in danger of losing everything, including our house. I am desperate for some way to provide for my family.

VI. Trauma and Abuse

Have you ever been the victim of, or is suspected to be the victim of abuse (physical, sexual, or emotional) or neglect? Please explain: _____

_____

_____

_____

Have you ever been accused of being the perpetrator of abuse, neglect, or domestic violence?

_____

Have you ever experienced any other traumas (experiencing or witnessing domestic violence, serious illness, death of a loved one, being kidnapped, held hostage, threatened with weapons, victim of stalking, witnessing a murder, a fire, 9/11/01, etc.)? Please explain:_____

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Did you react to this trauma with a sense of fear, helplessness, or horror to this traumatic event? (This may be exhibited in younger children by disorganized, agitated behavior):_____

Did you react to the trauma by spacing out: blank, frozen, numb expression/ reactions; excessive daydreaming, or excessive preoccupation with fantasy?_____

Did you deny or downplay the impact of a severe trauma and/ or did the client avoid thoughts, feelings, conversation, activities, places, or people that arose recollection of the trauma?_____

Do you experience psychological panic or anxiety when reminded of the trauma and/ or physical upsets (headaches, stomach, etc.) at reminders of the trauma? _____

Do you experience low self-worth (self-esteem), at reminders of trauma?_____

Did you exhibit inappropriate sexualized behavior, excessive aggression, or separation anxiety after exposure to this trauma? _____

VII. Drugs and Alcohol (Addictions):

Do you/ family members use tobacco (chew, cigars, cigarettes, etc.)? How much? _____

Do you/ family drink alcohol? How much and how often? _____

Do you/ family members use drugs (illegal, over-use of prescribed, or non-prescribed, etc.)? If so who? What Drugs? How much and how often?_____

Do you/ family members gamble? If so, expound: _____

Have you/ family members ever received Drug and Alcohol Treatment? (rehab, I.O.P., outpatient, etc.)

VIII. Military Background

Have you ever served in the military?_____

What branch? _____What rank? _____

How many years and where did they serve? _____

Any combat seen? _____

How were they discharged? Honorable/ Dishonorable? _____

Other comments: _____

IX. Medical Background.

Current Medications, Vitamins and Supplements (Topical and Oral):

Name of Medication	Dosage	How many times per day?	Prescribing Physcian

General Health Status: _____
Name address phone of family doctor: _____
_____
_____
When was your last physical exam? _____
In the past 6 months, any changes in sleeping patterns? _____
How many hours (average) of sleep do you get per night? _____
History of Chemical Dependence (drug addiction/ substance abuse)? _____
Allergies: _____
_____
Any neurological disorders (diagnosed by a neurologist)? _____
_____
Any known Intellectual Deficits and Disabilities (formerly known as Mental Retardation)?
Vision or Hearing Impairment? _____
_____
Present/Past Significant Illnesses or Injuries and Treatment Received: _____
_____
_____
Impact on life/ family _____
Physical Limitations: _____
_____
_____
Past Surgeries/Hospitalizations and Dates _____
_____
_____
_____

Pain Assessment:
Are you in pain? ___ No ___ Yes If yes, have you discussed this with anyone? _____
_____

Nutrition Screen:
Are you on a special diet? _____
Any changes in appetite? _____

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Is there any history of eating disorder? _____
Has anyone suspected you of having an eating disorder? _____
Have you had any significant weight loss/ gain, or changes in eating habits? _____
_____
_____
Do you think you are underweight/ over-weight? _____
_____

X. Family Mental Health History

Is there a family history of mental illness [i.e., mood problems, schizophrenia, psychosis, or problems with attention, activity and impulse (especially as a child)]? If so, please explain. _____
_____
Any known Intellectual Deficits and Disabilities (formerly known as Mental Retardation)?

XI. Social History

How do you interact with others? _____
_____
_____
Describe any needs or concerns in this area: _____
_____
_____
What do you do in your leisure or free time? _____
_____
_____
How many hours (average) do you use electronics (TV, computer, xbox, playstation, handhelds, etc.)?
Legal Problems? (Current and History – if applicable, complete table below)_____
_____

Date of Arrest	Charge	Sentence	Probation	Date released

Any pending issues? _____
Other stressors: _____
_____

Work History

Do you currently work? _____ If no, why not? _____
What is your current job(s)? _____
How long have you been at the current job? _____
How many jobs have you had in the past 10 years? _____
In the last 2 years, how many months have you worked? _____
Reason for terminating employment _____
Have you ever been fired or laid off? If so, how many times? _____

Educational History:

Highest completed _____ Average grades (high, avg. low, failing)_____

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Need special supports (gifted, learning, emotional)_____
Behavior Issues (detentions, suspensions, expulsions)_____
How often did you see the nurse? _____

Other Stressors:

Has the client ever been a victim of hate crimes? _____
_____
Any involvement in or exposure to school/work/community violence?_____
_____
Has the client ever been threatened physically with weapons/ held captive/ held hostage?
_____
Problems in work or school? _____
_____
Has the client had any losses, deaths , moves (especially in the past five years)? _____
_____
_____

Sexual History:

What is your primary sexual orientation?
___ Heterosexual - (i.e. straight)
___ Homosexual - (i.e. gay)
___ Bisexual

Gender Identity:
___ Cis-gender (same as birth)
___ Transgender (different from birth)
If not cis-gender, preferred pronoun? _____

Are there other sexual orientation/ gender identity issues that should be noted? _____
_____
At what age did you become sexually active?_____
Age you entered puberty? _____
Marital status? _____
Do you have any children? _____
Where do the children live?_____
_____
If female, how many miscarriages and abortions, if any? When? _____
_____
Do you view/ watch pornography? If so, how many hours per day/ week?_____
_____
Are there any other sexual history/ issues that should be noted? _____
_____

Is there any thing else that I should know about? _____
_____
_____
_____

XII. Goals

What do you hope to gain from these sessions in:
(A) One month _____
_____
(B) Three months _____

(C) Six months _____

What is your long-term goal for treatment? _____

Please read the following and sign:

We accept cash, personal checks, credit cards (MC, Visa, American Express, Discover), FSA and HAS debit cards. Please note there is a 4% convenience fee for using credit and debit cards.

We require 24Thour notification for cancelation of appointment. A fee of $60 will be assessed for all no-shows and all cancelations made with less than 24Thour notification. Future appointments will not be made until account is brought current and this fee is paid in full or payment arrangements are made.

Please initial the following:

I understand that fee is due at time of service: _____

I understand that there is a 4% convenience fee for using credit and debit cards: _____

I understand that there is a $60 fee for all *no-shows* and appointments canceled with less than 24-hours notice and that future appointments will not be made until this fee is paid in full: _____

I understand that there is a $50 service fee for all returned checks: _____

Patient signature _____ Date _____

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Assessment of Client and Family History (OFFICE USE ONLY)

DIAGNOSIS:

AXIS I: _____

_____

AXIS II: _____

_____

AXIS III: _____

_____

AXIS IV: _____

_____

AXIS V: _____

_____ _____

Victor J. Manocchio, MSW, LCSW Date