Patient Questionnaire BIOPSYCHOSOCIAL ASSESSMENT

Demographics

Client Name:	**Date:**
Current Address: Street City/State Zip Code	**Phone #: ( ) -**
Date of Birth:	**Marital/Relationship Status:**
Nation/Tribe/Ethnicity:	
Primary language of client:	**Secondary:**
Referral Source:	**Phone:**
Emergency Contact:	**Phone:**

Family Relationships

Does the client have any children?

Name	Age	Date of Birth	Sex	Custody? Y/N	Lives With?	Additional Information

Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)

Name	Age	Sex	Relationship	Additional Information

Primary language of household/family:	**Secondary:**

Family History

Family History of (select all that apply):						
	Mother	**Father**	**Siblings**	**Aunt**	**Uncle**	**Grandparents**
Alcohol/Substance Abuse	☐	☐	☐	☐	☐	☐
History of Completed Suicide	☐	☐	☐	☐	☐	☐
History of Mental Illness/Problems such as:	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Attention Deficit/Hyperactivity	☐	☐	☐	☐	☐	☐
Learning Disorders	☐	☐	☐	☐	☐	☐
School Behavior Problems	☐	☐	☐	☐	☐	☐
Incarceration	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐
Comments:						

Critical Population (choose all that apply)

Funding Source	Residential	Legal Involvement
☐ Food Stamp Recipient	☐ Homeless	☐ Protective Services (APS/CPS)
☐ TANF Recipient	☐ Shelter Resident	☐ Court Ordered Services
☐ SSI Recipient	☐ Long Term Care Eligibility	☐ On Probation
☐ SSDI Recipient	☐ Long Term Care Resident	☐ On Parole
☐ SSA (retirement) Recipient		☐ On Pre-Release
☐ Other Retirement Income	**Disability**	☐ Mandatory Monitoring
☐ Medicaid Recipient	☐ Physical Disability	
☐ Medicare Recipient	☐ Severely Mentally Ill	**Other**
☐ General Assistance	☐ SED	☐ Currently pregnant
	☐ Developmentally Disabled	☐ Woman w/dependents
	☐ Chronically Mentally Ill	
	☐ Regional Behavioral Health Authority	

Contact Information
(Secure consents for agency contacts, when possible)

Name of Caseworker	Agency	Phone number

Client's/Family's Presentation of the Problem:
Client's/Family's Expected Outcome:

Physical Functioning

Allergies (Medication & Other):
Current Medical Conditions:
Current Medications (include herbs, vitamins, & over-the-counter):
Past Medications:
Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including RTC, group home, therapeutic foster care, aftercare, inpatient psychiatric, outpatient counseling):

Dates	Inpt/Outpt	Location	Reason	Completed? Y/N

Surgeries:

Pain Questionnaire

Pain Management: Is the client in pain now? ☐ Yes ☐ No
If yes, ask client to rate the pain on a scale of 1-10 (with 10 being the severest) and enter score here

Is the client receiving care for the pain? ☐ Yes ☐ No
If no, would the client like a referral for pain management? ☐ Yes ☐ No

Nutrition

Nutritional Status: Current Weight	Current Height	BMI
Appetite: ☐ Good	☐ Fair	☐ Poor, please explain below
☐ Recently gained/lost significant weight		☐ Binges/overeats to excess
☐ Restricts food/Vomits/over-exercises to avoid weight gain		☐ Special dietary needs
☐ Hiding/hording food		☐ Food allergies
Comments		

Social

Supportive Social Network? (Rate the network using a scale of **1** Weak to **5** Strong)			
Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	
Comment:			
Living Situation:			
☐ Housing Adequate	☐ Housing Dangerous	☐ Ward of State/Tribal Court	☐ Dependent on Others
☐ Housing Overcrowded	☐ Incarcerated	☐ Homeless	☐ At Risk of Homelessness
Additional Information:			
Employment: Currently Employed?			
☐ **Yes** **Employer**		**Length of Employment**	
☐ Satisfied	☐ Dissatisfied	☐ Supervisor Conflict	☐ Co-worker Conflict
☐ **No** **Last Employer:**		**Reason for Leaving:**	
☐ **Never Employed**	☐ **Disabled**	☐ **Student**	☐ **Unstable Work History**
Financial Situation:			
Presence or absence of financial difficulties: (Fields below are optional)			
☐ No Current Problems	☐ Large Indebtedness	☐ Relationship Conflicts Over Finances	
☐ Impulsive Spending	☐ Poverty or Below	☐ Financial Difficulties	
Source of Income (choose all that apply)			
Employed: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Temporary ☐ Self-Employed		Unemployed: ☐ Actively seeking work ☐ Not looking for work	☐ Public Assistance
☐ Retirement	☐ SSD	☐ SSDI	☐ SSI
☐ Medical Disability via Employer		☐ Other:	
Military History:			
☐ **Never enlisted in Armed Forces, OR**			
☐ **Branch of Service:**		**Combat:** ☐ Yes	☐ No
Type of Discharge:	☐ Honorable	☐ Dishonorable	☐ Medical ☐ Other:
Sexual Orientation:			
☐ Heterosexual		☐ Bisexual	
☐ Homosexual		☐ Transgendered	
☐ N/A at this time		☐ Comment:	

Family Social History

Describe family relationships & desire for involvement in the treatment process:
Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive)

Legal Status Screening

Past or current legal problems (select all that apply)?		
☐ None	☐ Gangs	☐ DUI/DWI
☐ Arrests	☐ Conviction	☐ Detention
☐ Jail	☐ Probation	☐ Other:
If yes to any of the above, please explain:		
Any court-ordered treatment? ☐ Yes (explain below) ☐ No		
Ordered by	**Offense**	**Length of Time**

Education

Educational Level (select one): ☐ less than 12 years – enter grade completed		☐ Some college or tech school
☐ Unknown	☐ High School Grad/GED	☐ College Graduate
If still attending, current School/Grade:		
Vocational School/Skill Area:		
College/Graduate School – Years Completed/Major:		

Leisure & Recreation

Which of the following does the client do? (Select all that apply)			
Spend Time with Friends	☐	Sports/Exercise	☐
Classes	☐	Dancing	☐
Time with Family	☐	Hobbies	☐
Work Part-Time	☐	Watch Movies/TV	☐
Go “Downtown”	☐	Stay at Home	☐
Listen to Music	☐	Spend Time at Clubs/Bars	☐
Go to Casinos	☐	Other:	☐
What limits the client’s leisure/recreational activities?			

Functional Assessment

Is client able to care for him/herself? ☐ Yes ☐ No If No, please explain:			
Uses or Needs assistive or adaptive devices (select all that apply):			
☐ None	☐ Glasses	☐ Walker	☐ Braille
☐ Hearing Aids	☐ Cane	☐ Crutches	☐ Wheelchair
☐ Translated Written Information	☐ Translator for Speaking	☐ Other:	
Does the client have a history of falls? ☐ Yes ☐ No Explain:			

Psychological

History of Depressed Mood: ☐ **Yes** ☐ **No**		
History of irritability, anger or violence (tantrums, hurts others, cruel to animals, destroys property):		
Sleep Pattern: Number of hours per day Time to onset of sleep?		
☐ Normal	☐ Sleeping too much	☐ Sleeping too little
Ability to Concentrate: ☐ Normal ☐ Difficulty concentrating		
Energy Level: ☐ Low ☐ Average/Normal ☐ High		
History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal)? Select all that apply		
☐ Intrusive memories, thoughts, perceptions	☐ Nightmares	☐ Flashbacks
☐ Avoiding thoughts, feelings, conversations	☐ Numbing/detachment	☐ Restricted display of emotions
☐ Avoiding people, places, activities	☐ Poor sleep	☐ Irritability
☐ Hypervigilance	☐ Other:	
Any additional information:		

Bereavement/Loss & Spiritual Awareness

Please list significant losses, deaths, abandonments, traumatic incidents:
Spiritual/Cultural Awareness & Practice
Knowledgeable about traditions, spirituality, or religion? ☐Yes ☐No Comment:
Practices traditions, spirituality, or religion? ☐Yes ☐No Comment:
How does client describe his/her spirituality?
Does client see a traditional healer? ☐Yes ☐No Comment:

Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, medical, educational) or exploitation? ☐Yes ☐No
If yes, please explain:

Has client been abused at any time in the past or present by family, significant others, or anyone else?) ☐ No ☐ Yes, explain:

Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal Putdowns			
Being threatened			
Made to feel afraid			
Pushed			
Shoved			
Slapped			
Kicked			
Strangled			
Hit			
Forced or coerced into sexual activity			
Other			
Was it reported? ☐Yes ☐No	To whom?		
Outcome			

Has client ever witnessed abuse or family violence? ☐ No ☐ Yes, explain:

Behavioral Assessment

Abuse/Addiction – Chemical & Behavioral

Drug	Age First Used	Age Heaviest Use	Recent Pattern of Use (frequency & Amount, etc)	Date Last Used
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, speed, amphetamines, etc)				
Methamphetamine				
Inhalants (gas, paint, glue, etc)				
Hallucinogens (LSD, PCP, mushrooms, etc)				
Opioids (heroin, narcotics, methadone, etc)				
Sedative/Hypnotics (Valium, Phenobarb, etc)				
Designer Drugs/Other (herbal, Steroids, cough syrup, etc)				
Tobacco (smoke, chew)				
Caffeine				

Ever injected Drugs? ☐ Yes ☐ No **If Yes, Which ones?**

Drug of Choice?

Consequences as a Result of Drug/Alcohol Use (select all that apply)

☐ Hangovers	☐ DTs/Shakes	☐ Blackouts	☐ Binges
☐ Overdoses	☐ Increased Tolerance (need more to get high)	☐ GI Bleeding	☐ Liver Disease
☐ Sleep Problems	☐ Seizures	☐ Relationship Problems	☐ Left School
☐ Lost Job	☐ DUIs	☐ Assaults	☐ Arrests
☐ Incarcerations	☐ Homicide	☐ Other:	

Longest Period of Sobriety? **How long ago?**

Triggers to use (list all that apply):

Has client traded sex for drugs? ☐ No ☐ Yes, explain:

Has client been tested for HIV? ☐ Yes ☐ No

If yes, date of last test: **Results:**

Has client had any of the following problem gambling behaviors? Select all that apply:

☐ Gambled longer than planned	☐ Gambled until last dollar was gone
☐ Lost sleep thinking of gambling	☐ Used income or savings to gamble while letting bills go unpaid
☐ Borrowed money to gamble	☐ Made repeated, unsuccessful attempts to stop gambling
☐ Been remorseful after gambling	☐ Broken the law or considered breaking the law to finance gambling
☐ Other:	☐ Gambled to get money to meet financial obligations

Risk Taking/Impulsive Behavior (current/past) – select all that apply:

☐ Unprotected sex	☐ Shoplifting	☐ Reckless driving
☐ Gang Involvement	☐ Drug Dealing	☐ Carrying/using weapon
☐ Other:		