

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Why I came for Treatment:	How long have I had the problem?	Additional information:

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

- 0 = This symptom not present at this time
- 1 = This symptom is present, bothers you a little, but not enough to be a problem
- 2 = Symptom present, bothers you and affects your quality of life, but able to function OK
- 3 = Moderate impact on quality of life and/or day-to-day functioning
- 4 = Significant impact on quality of life and/or day-to-day functioning
- 5 = Serious impact on quality of life, interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Depressed Mood	0 1 2 3 4 5	Hearing/Seeing Things	0 1 2 3 4 5	Guilty Feelings	0 1 2 3 4 5
Worrying	0 1 2 3 4 5	Feel I'm Being Watched	0 1 2 3 4 5	Lump in Throat	0 1 2 3 4 5
Difficulty Concentrating	0 1 2 3 4 5	Feel Others Are Against Me	0 1 2 3 4 5	Heart Racing	0 1 2 3 4 5
Angry Feelings	0 1 2 3 4 5	Loss of Interest in Things	0 1 2 3 4 5	Twitches, Spasms	0 1 2 3 4 5
Angry Behavior	0 1 2 3 4 5	Temper Outbursts	0 1 2 3 4 5	Knot in Stomach	0 1 2 3 4 5
Feeling Anxious/Nervous	0 1 2 3 4 5	Thoughts Coming Too Fast	0 1 2 3 4 5	Fear of Places	0 1 2 3 4 5
Panic Attacks	0 1 2 3 4 5	Trouble With Memory	0 1 2 3 4 5	Grinding of Teeth	0 1 2 3 4 5
Sweaty Palms	0 1 2 3 4 5	Difficulty Concentrating	0 1 2 3 4 5	Back Pain	0 1 2 3 4 5
Mind Going Blank	0 1 2 3 4 5	Cry Easily	0 1 2 3 4 5	Upset Stomach	0 1 2 3 4 5
Poor Appetite	0 1 2 3 4 5	Tiredness or Fatigue	0 1 2 3 4 5	Chest Pain	0 1 2 3 4 5
Easily Annoyed/Irritated	0 1 2 3 4 5	Sleeping Too Much	0 1 2 3 4 5		0 1 2 3 4 5
Lump in Throat	0 1 2 3 4 5	Poor Appetite/Weight Loss	0 1 2 3 4 5		0 1 2 3 4 5
Difficulty Falling Asleep	0 1 2 3 4 5	Thoughts of Hurting Myself	0 1 2 3 4 5		0 1 2 3 4 5
Difficulty Staying Asleep	0 1 2 3 4 5	Thoughts of Killing Myself	0 1 2 3 4 5		0 1 2 3 4 5

EMOTIONAL/PSYCHIATRIC HISTORY

Have You Ever Been in Counseling Before? Yes No

Name of Counselor	Counselor Address	Counselor Phone No.	When Did You See Them?	How many Times?

Has any family member seen a counselor? Yes No

Which Family Member?	Relationship to You?	What was counseling for?

Were you ever in the hospital for a psychiatric or substance use disorder? Yes No

Name of Facility	City and State of Facility	Facility Phone Number	When Did You Go There?	For How Long?

Has any family member been hospitalized for a psychiatric or substance use disorder? Yes No

Which Family Member?	Relationship to You?	What was hospital stay for?

Do you take any medicine? No Yes **What Medicine?** _____

Has any family member used psychiatric medications? Yes No **If yes, who/what/why (list all):**

Emotional Health Problems of Family: (check all that apply)

	Mother	Father	Sister	Brother	Aunt	Uncle	Children	Grandparent
Anxiety								
Attention Deficit								
Bipolar Disorder								
Depression								
Eating Disorder								
Schizophrenia								
Post-Traumatic Stress								
Suicide Attempt								

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

Describe any past or current significant issues in other immediate family relationships: _____

SPIRITUALITY

No Yes

- Do you feel that you have a purpose in life?
- Do you believe in a power greater than yourself?
- Do you feel that your morals, beliefs and values have been compromised due to alcohol/drug use?
- Were you raised with a religion as a child?

If yes, what denomination? _____

- Do you have a religion that you currently practice?

If yes, what denomination? _____

- Do you currently practice any spiritual activities such as praying, attending church, member of choir, reading, mass, meditation, journal? If yes, list activities.

Briefly describe what the word “ GOD” means to you: _____

MEDICAL HISTORY (check all that apply)

Describe current physical health: Good Fair Poor

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

Name of Personal Physician: _____

- tuberculosis
- birth defects
- emotional problems
- behavior problems
- thyroid problems
- cancer
- mental retardation
- other chronic or serious health problems
- heart disease
- high blood pressure
- alcoholism
- drug abuse
- diabetes
- Alzheimer's/dementia
- stroke

Address: _____ **Phone:** _____

List name of psychiatrist: (if any): _____

Address: _____ **Phone:** _____

List any medications currently taken (give dosage & reason): _____

Date of last Physical Exam: _____

Describe any serious hospitalization or accidents:

List any abnormal lab test results:

Date _____ Age ____ Reason _____

Date _____ Result _____

Date _____ Age ____ Reason _____

Date _____ Result _____

Date: _____ Age ____ Reason _____

List any health problems currently being treated or have been treated for in the past:

CHRONIC PAIN PROBLEMS

Choose a number from 0-10 that best describes your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 N/A

Where is the pain located? _____ When did the pain start? _____

How long have you had this pain? _____ How often do you experience pain? _____

Does the pain affect activities (walking, shopping, exercise, etc)? _____

What makes the pain worse? _____

What makes the pain lessen? _____

OTHER MEDICAL HISTORY (check all that apply)

Allergies:

- Yes No
- Food allergies
- Medication Allergies
- Latex
- Environmental
- Animal

Females Only:

At what age did you start to menstruate: _____

Do you now have or ever had problems with your period: Yes No

Have you had any:

Males Only: Have you had problem in the past or are you presently having problems with your prostate, difficult or painful urination, or impotence?

Pregnancies? If yes, how many: _____ When: _____

Miscarriages? If yes, how many: _____ When: _____

Abortions? If yes, how many: _____ When: _____

Yes No

ADDICTION HISTORY (check all that apply for patient)

	Currently using/abusing (list substances used)	Used/abused, quit	Died/Health Problems Due to Use	
Father				
Mother				
Sister				
Brother				
Aunt				
Uncle				
Cousin				

Grandma				
Grandpa				
Husb/Wife				
Child(ren)				

	Age at 1 st Use	Used Recently (Last 6 mos.)		
Alcohol – Prefer <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor				
Amphetamines/Meth/Speed				
Barbiturates/Downers				
Cocaine/Crack				
Hallucinagens (LSD, mushrooms)				
Inhalants (paint, glue, gas)				
Marijuana/Hashish				
PCP				
Morphine/Heroin/Oxycontin				
Steroids				
MDMA/Ecstasy				
Prescription Drugs				
Other:				

Check all circumstances that apply to you regarding your use of drugs and/ or alcohol:

- Used to sleep Relieve Emotional Pain Morning Use To Avoid Withdrawal To Get Rid of Hallucinations Used to Relax Relieve Physical Pain Used Alone To Function Socially To Relieve Anxiety

Treatment history:

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

Consequences of substance abuse (check all that apply):

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

Withdrawal Symptoms:

- | | | |
|---|---|--|
| Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Tremors | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Sweats |
| <input type="checkbox"/> <input type="checkbox"/> Anxiousness | <input type="checkbox"/> <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Agitation | <input type="checkbox"/> <input type="checkbox"/> Nausea | <input type="checkbox"/> <input type="checkbox"/> Muscle or joint pain |
| <input type="checkbox"/> <input type="checkbox"/> Auditory Hallucinations | <input type="checkbox"/> <input type="checkbox"/> Vomiting | <input type="checkbox"/> <input type="checkbox"/> Cramps |

How old were you the first time you tasted alcohol? _____
 How old were you the first time you drank enough to become intoxicated? _____
 When did you start drinking regularly? _____
 When you first began drinking, how many drinks did it take for you to begin feeling the effects (get a buzz)? _____ How much did it take to feel intoxicated? _____

No Yes
 Has anybody complained about your alcohol/ drug use? Who? _____
 Have you ever received a DUI? How many? _____ Dates and BAT for each. _____
 Have you had any other legal problems where alcohol or drug were involved? Explain?

No Yes
 Have you ever awoken the morning after some drinking the night before and found that you could not remember part of the evening before?
 Have you ever gone for more than 3 days without using and not suffered any discomfort?
 Can you stop drinking or using drugs without a struggle after you have started drinking or using drugs?
 Have you ever taken a drink to keep from having withdrawal symptoms or to make them go away?
 Did you ever need a drink first thing in the morning, before breakfast, or before eating anything?
 Have you had any of the following problems when you stopped or cut down on your drinking? (check the ones that apply)
 Shakes **Seeing or hearing things that aren't there** **Heavy sweating, heart beating fast**
 Being unable to sleep **DT's**
 Feeling anxious or depressed fits or seizures
 Have you ever taken a drink to keep from having withdrawal symptoms or to make them go away?
 Did drinking ever cause you to have: (check the ones that apply)
 liver disease **Tingling or numbness in your feet**
 Stomach problems **Memory problems**
 Vomiting blood **Pancreatitis**
 Did you continue to drink, knowing it caused you to have health problems or injuries?
 Have you ever continued to drink while taking medication that was dangerous to take with alcohol?
 Has alcohol consumption ever caused you to feel: (check the ones that apply)
 uninterested in things **depressed** **paranoid**
 Did these problems cause you to cut down or stop drinking?
 Have you ever spent a lot of time getting, using, or getting over the effects?
 Have there been many days when you used much larger amounts of drugs than you intended to when you began?
 Have you tried to cut down on your drug use but found you couldn't?
 Did you ever feel sick because you stopped or cut down on drugs?
 Have you ever felt you needed larger amounts of drugs to get an effect?
 Do you have a history of injuries or health problems as a result of using drugs?
 Have you continued to use drugs in spite of these problems?
 Have drugs caused problems with your family, friends, workers, or with the police?
 Did these problems cause to cut down or stop using?
 Have you given up, or greatly reduced, important activities such as sports, work, or associating with friends or relatives in order to use drugs?

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

Problems during mother's pregnancy:	Birth:	Childhood health:	
<input type="checkbox"/> none	<input type="checkbox"/> normal delivery	<input type="checkbox"/> chickenpox (age _____)	<input type="checkbox"/> lead poisoning (age _____)
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> difficult delivery	<input type="checkbox"/> German measles (age _____)	<input type="checkbox"/> mumps (age _____)
<input type="checkbox"/> kidney infection	<input type="checkbox"/> cesarean delivery	<input type="checkbox"/> red measles (age _____)	<input type="checkbox"/> diphtheria (age _____)
<input type="checkbox"/> German measles	<input type="checkbox"/> complications _____	<input type="checkbox"/> rheumatic fever (age _____)	<input type="checkbox"/> poliomyelitis (age _____)
<input type="checkbox"/> emotional stress	birth weight ____lbs ____oz.	<input type="checkbox"/> whooping cough (age _____)	<input type="checkbox"/> pneumonia (age _____)
<input type="checkbox"/> bleeding	Infancy:	<input type="checkbox"/> scarlet fever (age _____)	<input type="checkbox"/> tuberculosis (age _____)
<input type="checkbox"/> alcohol use	<input type="checkbox"/> feeding problems	<input type="checkbox"/> autism	<input type="checkbox"/> mental retardation
		<input type="checkbox"/> ear infections	<input type="checkbox"/> asthma
		<input type="checkbox"/> allergies to _____	

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____

- drug use sleep problems significant injuries _____
- cigarette use toilet training problems chronic, serious health problems _____
- other _____

Delayed developmental milestones (check only those milestones that did not occur at expected age):

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

Emotional / behavior problems (check all that apply):

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

Social interaction (check all that apply):

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

Intellectual / academic functioning (check all that apply):

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

Describe any other developmental problems or issues: _____

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

Living situation:

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional
- drinking or drugs use in the home

Social support system:

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

Sexual history:

- heterosexual orientation currently sexually dissatisfied
 - homosexual orientation age first sex experience _____
 - bisexual orientation age first pregnancy/fatherhood _____
 - currently sexually active history of promiscuity age ___ to ___
 - currently sexually satisfied history of unsafe sex age ___ to ___
 - have sexual difficulty history of abortion
 - HIV testing when _____ history of miscarriage
 - sexually transmitted disease type _____ when _____
- Additional information: _____

Employment:

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

Military history:

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

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 engaged in hobbies? Yes No

currently participate in spiritual activities? Yes No

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

Financial situation:

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

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: _____

PERSONAL INSIGHT

Please identify your:

Strengths

Weaknesses

Please complete the following sentences:

I am feeling angry/ resentful because _____

I am afraid _____

I am feeling hopelessness about _____

 Patient Signature

 Date

<p>SOURCES OF DATA PROVIDED ABOVE: [] Patient self-report for all [] A variety of sources (if so, check appropriate sources below):</p>		
<p>Presenting Problems/Symptoms</p> <p>[] patient self-report [] patient's parent/guardian [] other (specify) _____</p>	<p>Family History</p> <p>[] patient self-report [] patient's parent/guardian [] other (specify) _____</p>	<p>Developmental History</p> <p>[] patient self-report [] patient's parent/guardian [] other (specify) _____</p>
<p>Emotional/Psychiatric History</p> <p>[] patient self-report [] patient's parent/guardian [] other (specify) _____</p>	<p>Medical/Substance Use History</p> <p>[] patient self-report [] patient's parent/guardian [] other (specify) _____</p>	<p>Socioeconomic History</p> <p>[] patient self-report [] patient's parent/guardian [] other (specify) _____</p>

IMMEDIATE NEED PROFILE

- 1. Acute Intoxication and/or Withdrawal Potential**
 No Yes
 [] [] Have you ever had life threatening withdrawal signs or symptoms?
 [] [] Are you currently having similar withdrawal symptoms?
- 2. Biomedical Conditions/ Complications**
 No Yes
 [] [] Do you have any current, untreated severe physical problems?
- 3. Emotional/Behavioral conditions/ complications**
 No Yes
 [] [] Do you feel that you are in danger or could harm yourself or someone else?
- 4. Treatment Acceptance/Resistance/ Readiness to Change**
 No Yes
 [] [] Do you feel you are in immediate need of alcohol treatment?
 [] [] Have you been referred or required to have an assessment and/or enter treatment by the criminal justice system, health or social services, work/school, or family/ significant other?
- 5. Relapse/Continued use Potential**
 No Yes
 [] [] Are you currently under the influence?
 [] [] Are you likely to continue use of alcohol and/or other drugs, or relapse, in an imminently dangerous manner?
- 6. Recovery Environment**
 No Yes
 [] [] Are there any dangerous family, significant others, living/work/school situations threatening your safety, immediate well-being and/or sobriety?

Mental Status

Assessment:

Appearance

- Neat
 Disheveled

Behavior

- Appropriate
 Aggressive

Insight

- Limited
 Absent

Mood

- Relaxed
 Calm/Serene

Patient name _____ Patient ID# _____ Patient SS# _____ Date _____

- Bizarre
- Poor Hygiene
- Formal
- Casual
- Tired
- Seductive
- Intoxicated
- Other

- Passive-Aggressive
- Crying/Tearful
- Demanding
- Guarded
- Hostile
- Uncooperative
- Arrogant
- Distracting
- Argumentative
- Other

- Distorted
- Improved
- Intellectualized
- Self Centered
- Other

- Elevated
- Anxious
- Depressed
- Fearful
- Angry
- Euphoric
- Apathetic
- Withdrawn
- Grieving
- Other

Judgment

- Rational
- Irrational
- Impaired
- Concrete
- Other

Self Image

- Unrealistic
- Adequate
- Poor Esteem
- Improved
- Other

Motivational Level

- High
- Good
- Average
- Minimal
- None
- Other

Progress

- Good
- Average
- Some
- Minimal
- None

SUMMARY

Diagnoses:

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

GAF Score Past year _____ Present _____

COMMENTS/RECOMMENDATIONS

- Level 0.5 Early Intervention
- Level I Outpatient Services
- Level II Intensive Outpatient / Partial Hospital Services
- Level III Residential/ Inpatient Services
- Level IV Medically Managed Intensive Inpatient Services

RESOURCES/REFERRALS NEEDED:

- Pain Management
- Financial
- Legal
- Psychiatric Evaluation
- Physician
- Support Group
- Medication Mgmt
- Psychological Testing
- Other

Counselors Signature

Date