



**Biopsychosocial Assessment**

**General Information**

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Admit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Presenting Problem: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code County

Telephone (Home): \_\_\_\_\_ Secondary: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: M  F

What is your dominant language? \_\_\_\_\_

Do you have trouble with either reading or writing English?  Yes  No

If YES, please describe: \_\_\_\_\_

Will this have any adverse affect on your ability to receive counseling?  Yes  No  N/A

If YES, please explain: \_\_\_\_\_

Do you use any assistive devices (i.e.: wheelchair, walking devices, etc.)  Yes  No

If YES, please describe: \_\_\_\_\_

Do you have a valid driver's license?  Yes  No

Other \_\_\_\_\_

**Emergency Contact Information:**

In case of an emergency, Contact Name: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Primary Medical Doctor: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Telephone # of PMD: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address of PMD: \_\_\_\_\_

**Descriptive Information:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Race / Ethnic Background:  White  Black  Am. Indian  Asian  Hispanic  Other: \_\_\_\_\_

Any identifying physical characteristics (scars, tattoos): \_\_\_\_\_

Have you been in a controlled environment in the last 30 days:  Yes  No If YES, please explain:

\_\_\_\_\_  
\_\_\_\_\_



**Substance Abuse History:**

Why are you seeking treatment at this time? \_\_\_\_\_

How old were you when you began using drugs / alcohol? \_\_\_\_\_

Do you currently consume alcohol?  Yes  No If YES, how much? \_\_\_\_\_

How many times have you had alcohol withdrawal symptoms? \_\_\_\_\_

Have you ever overdosed?  Yes  No If YES, please describe how many times and what type of drug(s): \_\_\_\_\_

What is your primary drug of choice? \_\_\_\_\_ Secondary? \_\_\_\_\_

What is your normal route of administration? \_\_\_\_\_

What has been the longest period of time you have been drug free? \_\_\_\_\_

How was this drug free time obtained? \_\_\_\_\_

What contributed to your relapse? \_\_\_\_\_

Do you feel you are at risk from withdrawal symptoms?  Yes  No

If YES, please describe: \_\_\_\_\_

Have you ever experienced an episode of amnesia or a "blackout" when you were using drugs or alcohol?  Yes  No

Have you ever experienced an episode of amnesia or a "blackout" when you were NOT using drugs or alcohol?  Yes  No

Have you ever attended any outside support groups?  Yes  No AA/NA?  Yes  No

If YES, please describe what benefited you the most. \_\_\_\_\_

Have you received previous treatment for a substance abuse issue?  Yes  No

If YES, please give name, location and type of treatment facility, date(s) attended, length attended, reason attended and outcomes/responses to treatment:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_



**Past and Current Drug History:**

Drugs or Alcohol used in the past 24 hours: \_\_\_\_\_

Drugs or Alcohol used in the past 72 hours: \_\_\_\_\_

How much and how often do you use: \_\_\_\_\_

Have you seen a progression in your use?  Yes  No If YES, please describe: \_\_\_\_\_

Do you think you need to use more to avoid withdrawal symptoms?  Yes  No If YES, please describe: \_\_\_\_\_

Have you made any attempts to reduce or stop your substance use?  Yes  No If YES, please describe: \_\_\_\_\_

Have you ever experienced any adverse consequences due to your substance abuse?  Yes  No If YES, please explain: \_\_\_\_\_

Have you ever engaged in IV drug use?  Yes  No

Have you ever shared needles?  Yes  No  N/A

What are your expectations / outcomes from this treatment? \_\_\_\_\_

What specific problems do you want to address while in treatment? \_\_\_\_\_

Patient's self reported:

Strengths: \_\_\_\_\_

Needs: \_\_\_\_\_

Abilities: \_\_\_\_\_

Treatment Preferences: \_\_\_\_\_

Patient's self reported problems and challenges: \_\_\_\_\_

Patient's self reported interests and activities: \_\_\_\_\_

Do you have special preferences about the way we provide services to you? \_\_\_\_\_

List other people that you would like to be involved in your treatment and their relationship to you: \_\_\_\_\_



Type Of Drug Used	Past History Year Of First Use	Current Usage Past 30 Days		Frequency / length and patterns of use	Last Use
		Yes	No		
Heroin					
Morphine					
Dilaudid					
Illegal Methadone					
Oxycontin					
Other opiate/opioid					
Benzodiazepines					
Alcohol					
Barbiturates					
Methaqualone					
Amphetamines					
Cocaine					
Marijuana					
Tobacco					
Hallucinogens					
Inhalants					
Others (list)					

Frequency of Use

**1** = 1 time or less per week  
**4** = 1 time daily

**2** = 2 times per week  
**5** = 2-3 times daily

**3** = 3-4 times per week  
**6** = 4 or more times daily

First Choice: \_\_\_\_\_ Second Choice: \_\_\_\_\_ Third Choice: \_\_\_\_\_

In summary, what has been the impact of drug / alcohol use on your life?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Mental Health History:**

How many times have you been treated for psychological or emotional problems? \_\_\_\_\_

In what setting? \_\_\_\_\_

Length of time for each occurrence: \_\_\_\_\_

Have you ever been diagnosed with a mental health illness?  Yes  No If YES, please give diagnosis, date diagnosed and practitioner and/or facility that provided diagnosis: \_\_\_\_\_

Have you ever had any suicidal ideations or attempts at suicide?  Yes  No If YES, please describe in detail, date(s), number of attempts and reason(s): \_\_\_\_\_

Do you currently have any suicidal, aggressive or homicidal ideation?  Yes  No If YES, please explain: \_\_\_\_\_

Are you interested in receiving treatment for mental health issues?  Yes  No

**Medical History:**

Are you currently taking any medications prescribed to you?  Yes  No  
If YES, please provide medication, dosage, frequency and prescribing physician name and address:

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Do you have any current or past medical issues?  Yes  No If YES, please describe: \_\_\_\_\_

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Have you ever been hospitalized?  Yes  No If YES, what for? \_\_\_\_\_

Have you had any operations and / or surgeries?  Yes  No If YES, please describe: \_\_\_\_\_

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Do you have any chronic medical problems that continue to interfere with your life?  Yes  No If YES, please explain: \_\_\_\_\_

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Do you have any medication allergies?  Yes  No If YES, please describe: \_\_\_\_\_

Date of last physical and name of physician who performed it: \_\_\_\_\_

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Please identify any specific current medical needs:

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**Family History:**

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name of Sibling(s) and Age: 1. \_\_\_\_\_ Age: \_\_\_\_\_ 2. \_\_\_\_\_ Age: \_\_\_\_\_

3. \_\_\_\_\_ Age: \_\_\_\_\_ 4. \_\_\_\_\_ Age: \_\_\_\_\_

Is there any current or past family history of substance abuse?  Yes  No If YES, please describe: \_\_\_\_\_

Is there any current or past family history of mental health / psychiatric issues?  Yes  No

If YES, please describe: \_\_\_\_\_

Is there any current or past family history of medical issues (diabetes, etc.)?  Yes  No

If YES, please describe: \_\_\_\_\_

Raised by:  Parents  One Parent  Relatives  Foster  Adoptive

Describe your childhood: \_\_\_\_\_

Describe your past and current relationships with parents/siblings: \_\_\_\_\_

List or describe how your substance abuse or another family member's substance abuse has affected your family: \_\_\_\_\_

Were you or any other family member emotionally, physically or sexually abused?  Yes  No

If YES, please list the relationship of the abused, abuser and type of abuse: \_\_\_\_\_

Have you ever been the victim of violence (i.e. combat, mugging, etc)? If so, please explain \_\_\_\_\_

Are you experiencing any family problems?  Yes  No If YES, please explain: \_\_\_\_\_

Are you interested in counseling for family problems?  Yes  No

Is your family or significant other supportive of you entering into treatment?  Yes  No

Explain who is and is not supportive and why: \_\_\_\_\_

Will your family or significant other participate in your treatment?  Yes  No If YES, please explain: \_\_\_\_\_



What is your family / significant other's expectation of your treatment? \_\_\_\_\_

Do you have a support network in place?  Yes  No Please describe: \_\_\_\_\_

Interview with family / significant other (if applicable): \_\_\_\_\_

With whom do you spend most of your free time and how? \_\_\_\_\_

Are you experiencing any social problems?  Yes  No If YES, please explain: \_\_\_\_\_

Are you interested in counseling for social problems?  Yes  No

**Education:**

What was the highest grade you completed? \_\_\_\_\_ GED:  Yes  No  N/A

If you did not graduate, explain why: \_\_\_\_\_

Training or technical education completed? \_\_\_\_\_

Are you interested in furthering your education?  Yes  No

Do you currently have or ever had any behavioral, learning disabilities or traumatic experiences that are significant to educational history?  Yes  No If YES, please explain: \_\_\_\_\_

List or describe any substance abuse history that created problems and / or consequences that occurred during school years. \_

College graduate?  Yes  No If YES, type of degree: \_\_\_\_\_

If NO, how long did you attend? \_\_\_\_\_ Why did you leave? \_\_\_\_\_

Graduate School?  Yes  No If YES, type of degree \_\_\_\_\_

Internships/Residencies? \_\_\_\_\_

**Relationship / Marital History:**

Status:  Married  Divorced  Separated  Widowed  Significant Other  Single

How many times have you been married / length of time for each marriage? \_\_\_\_\_

If currently married or in a relationship, name and age of partner: \_\_\_\_\_

Is partner living with you?  Yes  No If YES, please describe: \_\_\_\_\_

What have been your usual living arrangements for the past three years? \_\_\_\_\_

Do you live with anyone who:

a. Has a current alcohol problem?  Yes  No b. Uses non-prescribed drugs?  Yes  No

Have you experienced any domestic violence issues?  Yes  No

If YES, please describe: \_\_\_\_\_

Do you have any children?  Yes  No If YES, please list their names, ages, sex, and where they reside: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Are there any current or past problems with your children?  Yes  No If YES, please describe:

Are you satisfied with your current relationship?  Yes  No If NO, please explain: \_\_\_\_\_

Are you interested in family or couples counseling?  Yes  No

Has any relationship dissolved due to alcohol / drug problem?  Yes  No

**Cultural / Spiritual History:**

How would you describe your religious or spiritual background? How did it affect you?: \_\_\_\_\_

How would you describe your current religious or spiritual beliefs, orientation, and practice?: \_\_\_\_\_

Do you attend formal religious / spiritual practice?  Yes  No

Is it a significant part of your life?  Yes  No Do you meditate or pray regularly?  Yes  No

How has your substance abuse affected your spiritual aspect of life? \_\_\_\_\_

Do you feel your spiritual belief/higher power will have an impact on your recovery?  Yes  No

If YES, please describe: \_\_\_\_\_

History of cultural influences: \_\_\_\_\_

Are there any cultural, racial or ethnic background issues that will impact your recovery?  Yes  No

If YES, please explain in detail: \_\_\_\_\_

What is your cultural attitude towards substance abuse? \_\_\_\_\_

**Sexual History / Orientation:**

At what age did you have your first sexual experience? \_\_\_\_\_ How old was the other party? \_\_\_\_\_

Describe your current sexual orientation: \_\_\_\_\_

Have you always had the same sexual orientation:  Yes  No

Are you experiencing any problems regarding your sexual orientation?  Yes  No If YES, please describe: \_\_\_\_\_

Have you had multiple sexual partners?  Yes  No Have you ever engaged in unprotected sex?  Yes  No

**Recreation:**

Describe what type of recreation activities you currently enjoy: \_\_\_\_\_



Describe what type of recreation activities you would like to learn or start to engage in: \_\_\_\_\_

**Employment History:**

Are you currently employed?  Yes  No If NO, please explain how you support yourself: \_\_\_\_\_

How will you finance your treatment? \_\_\_\_\_

Name, address and phone # of current employer: \_\_\_\_\_

Describe your job: \_\_\_\_\_

Recent job history (jobs held, where, when and reason for leaving): \_\_\_\_\_

How long have you been at your current job? \_\_\_\_\_

Is your substance abuse affecting your current job?  Yes  No If YES, please explain: \_\_\_\_\_

Has anyone at work expressed concern about your substance abuse?  Yes  No If YES, please describe: \_\_\_\_\_

Vocational interests and goals: \_\_\_\_\_

Would employment counseling be of interest to you now?  Yes  No

Average monthly income: \_\_\_\_\_ Source: \_\_\_\_\_

Does someone contribute to your financial support?  Yes  No If YES, please explain \_\_\_\_\_

Do people depend on you for basic needs (food, shelter, etc.)?  Yes  No If YES, please explain \_\_\_\_\_

**Legal History:**

Have you ever been arrested?  Yes  No If YES, please give number of, dates of, reason for and disposition of arrest(s): \_\_\_\_\_

Have any of your charges resulted in convictions?  Yes  No

Have you ever been incarcerated?  Yes  No If YES, for how long? \_\_\_\_\_

Are you currently on probation or parole?  Yes  No If YES, please explain: \_\_\_\_\_

Name and address of probation or parole officer (release signed:  Yes  No: \_\_\_\_\_

Have you ever been charged with Driving While Intoxicated?  Yes  No If YES, how many times \_\_\_\_\_

Do you have any pending legal issues (awaiting charges, trial or sentencing)?  Yes  No If YES, please explain: \_\_\_\_\_

Do you have special probation, parole or court conditions regarding treatment?  Yes  No If YES, please explain: \_\_\_\_\_



Describe how your substance abuse has affected your legal history: \_\_\_\_\_

\_\_\_\_\_

Would counseling for legal issues be of interest to you now?  Yes  No

**Military History:**

Have you ever been in the Armed Forces?  Yes  No If YES, please provide dates of service, branch of service; any issues related to combat: \_\_\_\_\_

\_\_\_\_\_

Date and type of discharge: \_\_\_\_\_

Are you eligible for Veteran's Administration benefits?  Yes  No

**Losses:**

What significant losses or deaths of loved ones or others have you experienced? Please describe the relationship and the date of the loss: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Traumas:**

Please describe any other traumas you have witnessed or experienced (for example, crimes against others, abuse of others, car accident, natural disaster, effects of war, gross humiliation of others, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Client Identified Problems** – What you would like to see addressed during your receipt of treatment:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_