

Biopsychosocial History

Presenting Problems

Primary _____

Secondary _____

Current Symptom Checklist (Rate intensity of symptoms currently present)

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate = 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

<u>Symptom</u>	<u>Impact</u>				<u>Symptom</u>	<u>Impact</u>			
	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Aggressive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laxative/Diuretic Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loose Associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions/Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bingeing/Purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circumstantial Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concomitant Medical Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid Ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Trauma Victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissociative States	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elimination Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychomotor Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Trauma Victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/Low Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Trauma Victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Significant Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatic Complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Emotional/Psychiatric History

Prior outpatient psychotherapy?

No Yes If yes, on _____ occasions. Longest treatment by _____ for _____ sessions from ____/____/____ to ____/____/____
 Provider Name Month/Year Month/Year

<u>Prior provider name</u>	<u>City</u>	<u>State</u>	<u>Diagnosis</u>	<u>Intervention/Modality</u>	<u>Beneficial?</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Has any family member had outpatient psychotherapy?

No Yes If yes, who/why (list all):

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

No Yes If yes, on _____ occasions. Longest treatment at _____ from ____/____/____ to ____/____/____
 Name of facility Month/Year Month/Year

<u>Inpatient facility name</u>	<u>City</u>	<u>State</u>	<u>Diagnosis</u>	<u>Intervention/Modality</u>	<u>Beneficial?</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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? If yes:

No Yes

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Start Date</u>	<u>End Date</u>	<u>Physician</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Has any family member used psychotropic medications? If yes, who/what/why (list all):

No Yes

Family History

Family of Origin

Present during childhood

	Present entire childhood	Present part of childhood	Not Present at all
mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe parents

	<u>Father</u>	<u>Mother</u>
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Parents' current marital status

- married to each other
- separated for ____ years
- divorced for ____ years
- mother remarried ____ times
- father remarried ____ times
- mother involved with someone
- father involved with someone
- mother deceased for ____ years
age of patient at mother's death ____
- father deceased for ____ years
age of patient at father's death ____

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

Age of emancipation from home: _____

Circumstances that contribute to emancipation

Special circumstances in childhood

Immediate Family

Marital status

- single, never married
- engaged _____ months
- married for ____ years
- divorced for ____ years
- separated for ____ years
- divorce in process _____ months
- live-in for _____ years
- _____ prior marriages (self)
- _____ prior marriages (partner)

Intimate relationship

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

Relationship satisfaction

- 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 biological / adopted 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 _____

Medical History (check all that apply for patient)

Describe current physical health Good Fair Poor

List name of primary care physician

Name _____ Phone _____

List name of psychiatrist (if any):

Name _____ Phone _____

List any non-psychiatric medications currently being taken (give dosage and reason)

List any known allergies

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

- | | |
|---|---|
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> birth defects | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> emotional problems | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> behavior problems | <input type="checkbox"/> drug abuse |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> cancer | <input type="checkbox"/> Alzheimer's disease/dementia |
| <input type="checkbox"/> mental retardation | <input type="checkbox"/> stroke |
| <input type="checkbox"/> other chronic or serious health problems _____ | |

Describe any serious hospitalization or accidents

<u>Year</u>	<u>Age</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any abnormal lab test results

<u>Year</u>	<u>Result</u>
_____	_____
_____	_____
_____	_____

Substance Use History (check all that apply for patient)

Family alcohol/drug abuse history

- | | |
|---|---|
| <input type="checkbox"/> father | <input type="checkbox"/> stepparent/live-in |
| <input type="checkbox"/> mother | <input type="checkbox"/> uncle(s)/aunt(s) |
| <input type="checkbox"/> grandparent(s) | <input type="checkbox"/> spouse/significant other |
| <input type="checkbox"/> sibling(s) | <input type="checkbox"/> children |
| <input type="checkbox"/> other _____ | |

Substance use status

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

Patient Treatment history

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

Substances used

<u>Substances used</u>	<u>First use age</u>	<u>Last use age</u>	<u>Current Use</u>	<u>Frequency</u>	<u>Amount</u>
<input type="checkbox"/> alcohol	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> barbiturates/owners	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> cocaine	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> hallucinogens (e.g., LSD)	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> inhalants (e.g., glue, gas)	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> marijuana or hashish	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> opioids	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> PCP	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> prescription	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> other	_____	_____	<input type="checkbox"/>	_____	_____

Consequences of substance abuse

- | | | |
|--|---|--|
| <input type="checkbox"/> hangovers | <input type="checkbox"/> medical conditions | <input type="checkbox"/> suicide attempts |
| <input type="checkbox"/> seizures | <input type="checkbox"/> Increase in tolerance | <input type="checkbox"/> suicidal impulse/thoughts |
| <input type="checkbox"/> blackouts | <input type="checkbox"/> loss of control over amount used | <input type="checkbox"/> relationship conflicts |
| <input type="checkbox"/> Accidental overdose | <input type="checkbox"/> job loss | <input type="checkbox"/> arrests |
| <input type="checkbox"/> binges | <input type="checkbox"/> sleep disturbance | |
| <input type="checkbox"/> withdrawal symptoms | <input type="checkbox"/> assaults | |
| <input type="checkbox"/> other _____ | | |

Developmental History (check all that apply for 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
- _____
- _____

Infancy Problems

- none
- feeding problems
- sleep problems
- toilet training problems

birth weight _____ lbs _____ oz.

Childhood health

- | | |
|---|--|
| <input type="checkbox"/> chickenpox (age) _____ | <input type="checkbox"/> lead poisoning (age) _____ |
| <input type="checkbox"/> German measles (age) _____ | <input type="checkbox"/> mumps (age) _____ |
| <input type="checkbox"/> red measles (age) _____ | <input type="checkbox"/> diphtheria (age) _____ |
| <input type="checkbox"/> rheumatic fever (age) _____ | <input type="checkbox"/> poliomyelitis (age) _____ |
| <input type="checkbox"/> whooping cough (age) _____ | <input type="checkbox"/> pneumonia (age) _____ |
| <input type="checkbox"/> scarlet fever (age) _____ | <input type="checkbox"/> tuberculosis (age) _____ |
| <input type="checkbox"/> autism | <input type="checkbox"/> mental retardation |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> asthma |

- allergies to _____
- significant injuries _____
- chronic, serious health problems _____

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

- | | |
|--|--|
| <input type="checkbox"/> sitting | <input type="checkbox"/> controlling bowels |
| <input type="checkbox"/> rolling over | <input type="checkbox"/> sleeping alone |
| <input type="checkbox"/> standing | <input type="checkbox"/> dressing self |
| <input type="checkbox"/> walking | <input type="checkbox"/> engaging peers |
| <input type="checkbox"/> feeding self | <input type="checkbox"/> tolerating separation |
| <input type="checkbox"/> speaking words | <input type="checkbox"/> playing cooperatively |
| <input type="checkbox"/> speaking sentences | <input type="checkbox"/> riding tricycle |
| <input type="checkbox"/> controlling bladder | <input type="checkbox"/> riding bicycle |
| <input type="checkbox"/> other _____ | |

Emotional / behavior problems (check all that apply):

- none
- drug use
- alcohol abuse
- chronic lying
- stealing
- violent temper
- fire-setting
- hyperactive
- animal cruelty
- assaults others
- disobedient
- other _____
- repeats words of others
- not trustworthy
- hostile/angry mood
- indecisive
- immature
- bizarre behavior
- self-injurious threats
- frequently tearful
- lack of attachment
- distrustful
- extreme worrier
- self-injurious acts
- impulsive
- easily distracted
- poor concentration
- often sad
- breaks things in anger

Social interaction

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

Intellectual / academic functioning

- normal intelligence
- high intelligence
- learning problems
- authority conflicts
- attention problems
- underachieving
- mild retardation
- moderate retardation
- severe retardation

Current or highest education level _____

Describe any other developmental problems or issues

Socio-Economic History

Living situation

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

Social support system

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

Military

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

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

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

Sexual history

- 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 _____ to _____
- history of unsafe sex age _____ to _____

Additional information

Cultural/spiritual/recreational history

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

Describe any cultural issues that contribute to current problem and/or should be taken into account during treatment planning

- currently active in community/recreational activities?
- formerly active in community/recreational activities?
- currently engage in hobbies?
- currently participate in spiritual activities?

If answered "yes" to any of above, describe

Sources of Data Provided Above

- Patient self-report for all
- A variety of sources

Presenting Problems/Symptoms

- patient self-report
- patient's parent/guardian
- other _____

Family History

- patient self-report
- patient's parent/guardian
- other _____

Developmental History

- patient self-report
- patient's parent/guardian
- other _____

Emotional/Psychiatric History

- patient self-report
- patient's parent/guardian
- other _____

Medical/Substance Use History

- patient self-report
- patient's parent/guardian
- other _____

Socioeconomic History

- patient self-report
- patient's parent/guardian
- other _____