

Patient name: \_\_\_\_\_

Patient's SS# \_\_\_\_\_

Date \_\_\_\_\_

## BIOPSYCHOSOCIAL HISTORY

### PRESENTING PROBLEMS

**Presenting problems:**

**Duration (months):**

**Additional information:**

### CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

**None** = This symptom not present at this time • **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

	None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]
Agitation	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]
Irritability	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]
Obsessions/compulsions	[ ]	[ ]	[ ]	[ ]

	None	Mild	Moderate	Severe
bingeing/purging	[ ]	[ ]	[ ]	[ ]
laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]
anorexia	[ ]	[ ]	[ ]	[ ]
paranoid ideation	[ ]	[ ]	[ ]	[ ]
circumstantial symptoms	[ ]	[ ]	[ ]	[ ]
loose associations	[ ]	[ ]	[ ]	[ ]
delusions	[ ]	[ ]	[ ]	[ ]
hallucinations	[ ]	[ ]	[ ]	[ ]
aggressive behaviors	[ ]	[ ]	[ ]	[ ]
conduct problems	[ ]	[ ]	[ ]	[ ]
oppositional behavior	[ ]	[ ]	[ ]	[ ]
sexual dysfunction	[ ]	[ ]	[ ]	[ ]
grief	[ ]	[ ]	[ ]	[ ]
hopelessness	[ ]	[ ]	[ ]	[ ]
social isolation	[ ]	[ ]	[ ]	[ ]
Worthlessness	[ ]	[ ]	[ ]	[ ]

Patient name: \_\_\_\_\_

	None	Mild	Moderate	Severe
guilt	[ ]	[ ]	[ ]	[ ]
elevated mood	[ ]	[ ]	[ ]	[ ]
hyperactivity	[ ]	[ ]	[ ]	[ ]
dissociative states	[ ]	[ ]	[ ]	[ ]
somatic complaints	[ ]	[ ]	[ ]	[ ]
self-mutilation	[ ]	[ ]	[ ]	[ ]
significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
concomitant medical condition	[ ]	[ ]	[ ]	[ ]
emotional trauma victim	[ ]	[ ]	[ ]	[ ]
physical trauma victim	[ ]	[ ]	[ ]	[ ]
sexual trauma victim	[ ]	[ ]	[ ]	[ ]
emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
substance use/abuse	[ ]	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]	[ ]



Patient name: \_\_\_\_\_

**[ ] [ ] 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

Inpatient facility name Beneficial?	City	State	Phone	Diagnosis	Intervention/Modality
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**[ ] [ ] Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes, who/why (list all):**

No Yes

**[ ] [ ] Prior or current psychotropic medication usage?**

No Yes If yes:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?
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**[ ] [ ] Has any family member used psychotropic medications?**

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

## FAMILY HISTORY

### FAMILY OF ORIGIN

#### Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

#### 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 parents:

**Father**

full name \_\_\_\_\_

Occupation \_\_\_\_\_

education level \_\_\_\_\_

general health \_\_\_\_\_

**Mother**

full name \_\_\_\_\_

occupation \_\_\_\_\_

education level \_\_\_\_\_

general health \_\_\_\_\_

#### 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

Patient name: \_\_\_\_\_

Age of emancipation from home: \_\_\_\_\_

**Circumstances:**

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**Special circumstances in childhood:**

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**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 serious relationship
- not currently in relationship
- currently in a serious relationship

**Relationship satisfaction:**

- very satisfied with relationship
- satisfied with relationship
- somewhat satisfied with relationship
- somewhat dissatisfied with relationship
- dissatisfied with relationship
- very dissatisfied with relationship

Patient name: \_\_\_\_\_

**List all persons currently living in patient's household:**

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**List children not living in same household as patient:**

Name	Age	Sex	Location of Their Residence	Frequency of Visitation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Describe any past or current significant issues in intimate relationships**

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

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Patient name: \_\_\_\_\_

**MEDICAL HISTORY**  
(check all that apply for patient)

**Describe current physical health:**

- Excellent
- Good
- Fair
- Poor
- Very Poor

**List name of primary care physician:**

Name \_\_\_\_\_ Phone number \_\_\_\_\_

**List name of psychiatrist (if any):**

Name \_\_\_\_\_ Phone number \_\_\_\_\_

**List any medications currently being taken (give &):**

medications	dosage	reason

**List any known allergies:**

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**List any abnormal lab test results:**

Date \_\_\_\_\_ Result \_\_\_\_\_

Date \_\_\_\_\_ Result \_\_\_\_\_

Date \_\_\_\_\_ Result \_\_\_\_\_

Date \_\_\_\_\_ Result \_\_\_\_\_

**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 hospitalizations or accidents:**

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason \_\_\_\_\_

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason \_\_\_\_\_

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason \_\_\_\_\_

**SUBSTANCE USE HISTORY**

(check all that apply for patient)

**Family alcohol/drug abuse history:**

- father                       stepparent/live-in
- mother                         uncle(s)/aunt(s)
- grandparent(s)     spouse/significant other
- sibling(s)                       children
- other \_\_\_\_\_

**Substance use status:**

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

**Treatment history:**

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

**Substances used** (complete all that apply):

Current Use?	First use age	Last use age	(Yes/No)	Current frequency	Current amount
<input type="checkbox"/> alcohol	_____	_____	_____	_____	_____
<input type="checkbox"/> amphetamines/"speed"	_____	_____	_____	_____	_____
<input type="checkbox"/> barbiturates/"downers"	_____	_____	_____	_____	_____
<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____
<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (e.g., glue, gasoline)	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana or hashis	_____	_____	_____	_____	_____
<input type="checkbox"/> nicotine/cigarettes	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____	_____
<input type="checkbox"/> prescription	_____	_____	_____	_____	_____
<input type="checkbox"/> other _____	_____	_____	_____	_____	_____

**Consequences of substance use** (check all that apply):

- |   |  |  |                                   |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> hangovers              | <input type="checkbox"/> withdrawal symptoms   | <input type="checkbox"/> sleep disturbance           | <input type="checkbox"/> binges   |
| <input type="checkbox"/> seizures               | <input type="checkbox"/> medical complications | <input type="checkbox"/> assaults                    | <input type="checkbox"/> job loss |
| <input type="checkbox"/> blackouts              | <input type="checkbox"/> tolerance changes     | <input type="checkbox"/> suicidal impulse            | <input type="checkbox"/> arrests  |
| <input type="checkbox"/> relationship conflicts | <input type="checkbox"/> overdose              | <input type="checkbox"/> loss of control amount used | <input type="checkbox"/>          |
| <input type="checkbox"/> other: _____           |  |  |                                   |

**DEVELOPMENTAL HISTORY**

(check all that apply for a 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:** birth weight \_\_\_\_\_ lbs \_\_\_\_\_ oz.

- normal delivery
- difficult delivery
- cesarean delivery
- complications

**Infancy:**

- feeding problems
- sleep problems
- toilet training problems

Patient name: \_\_\_\_\_

**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                     |
| <input type="checkbox"/> allergies to                     |   |
| <input type="checkbox"/> significant injuries             |   |
| <input type="checkbox"/> chronic, serious health problems |   |

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

**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               |  |

**Social interaction** (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> normal social interaction | <input type="checkbox"/> inappropriate sex play           |
| <input type="checkbox"/> isolates self             | <input type="checkbox"/> dominates others                 |
| <input type="checkbox"/> very shy                  | <input type="checkbox"/> associates with acting-out peers |
| <input type="checkbox"/> alienates self            | <input type="checkbox"/> other                            |

Patient name: \_\_\_\_\_

**Emotional / behavior problems** (check all that apply):

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

**Intellectual / academic functioning** (check all that apply):

- 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:**

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**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

**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

**Social support system:**

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

Patient name: \_\_\_\_\_

**Military history:**

- never in military
- branch \_\_\_\_\_ status \_\_\_\_\_ (active, retired, reserve or NG)
- current or highest rank \_\_\_\_\_
- years in service \_\_\_\_\_
- served in combat
- honorably discharged
- dishonorably discharged
- medically discharged

**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 of 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:

- 
- |  |         |        |
|--|---------|--------|
| currently active in community/recreational activities? | Yes [ ] | No [ ] |
| formerly active in community/recreational activities?  | Yes [ ] | No [ ] |
| currently engage in hobbies?                           | Yes [ ] | No [ ] |
| currently participate in spiritual activities?         | Yes [ ] | No [ ] |

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

Patient name: \_\_\_\_\_

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SOURCES OF DATA PROVIDED ABOVE:

- Patient self-report for all
- A variety of sources (if so, check appropriate sources below):

**Presenting Problems/Symptoms**

- patient self-report
- patient's parent/guardian
- other (specify)\_\_\_\_\_

**Emotional/Psychiatric History**

- patient self-report
- patient's parent/guardian
- other (specify)\_\_\_\_\_

**Family History**

- patient self-report
- patient's parent/guardian
- other (specify)\_\_\_\_\_

**Medical/Substance Use History**

- patient self-report
- patient's parent/guardian
- other (specify)\_\_\_\_\_

**Developmental History**

- patient self-report
- patient's parent/guardian
- other (specify)\_\_\_\_\_

**Socioeconomic History**

- patient self-report
- patient's parent/guardian
- other (specify)\_\_\_\_\_