Bio-Psycho-Social Assessment(DCF-Compliant)

Date of Assessment: _____ dd / mm / yyyy

Client Full Name: _____

Date of Birth: _____ dd / mm / yyyy

Age: _____

Gender: _____

Pronouns: _____

Social Security #: _____

Phone: _____

Email: _____

Address: _____

Name of Emergency Contact: _____

Relationship with Emergency Contact: _____

Phone Number of Emergency Contact: _____

Preferred Contact Method:

◯ Phone ◯ Text ◯ Email

Chief Complaint (Client's own words):

Onset of Current Problems:

◯
◯ 1-6 months
◯ 6-12 months
◯ >1 year
◯ Most of life

Primary Concerns:

☐ Substance Use
☐ Depression
☐ OCD
☐ Sleep Issues
☐ Family Conflict
☐ Anxiety
☐ Trauma
☐ Eating Concerns
☐ Legal Issues
☐ Other

Client Strengths:

Client Barriers to Treatment:

Self-Harm History:

◯ None ◯ Yes

If yes, describe:

Homicide/Aggression Risk:

◯ None ◯ Yes

If yes, describe:

Elopement Risk:

◯ None ◯ Yes

Abuse Reporting Screen: Do you feel safe at home?: _____

Current Symptoms:

- ☐ Anxiety
- ☐ Depression
- ☐ OCD
- ☐ Mood swings
- ☐ Hallucinations
- ☐ Panic
- ☐ Trauma
- ☐ Irritability
- ☐ Sleep disturbance
- ☐ Paranoia

Past Counseling:

Where/When: _____

Psych Hospitalizations:

Psychotropic Medications:

Medication: _____ **Dose:** _____

Prescriber: _____

Current Medical Conditions:

PCP Name: _____ **Last Physical Exam Date:** _____ dd / mm / yyyy

TB Screening:

◯ Completed ◯ Needs Referral

Allergies:

Current Medical Medications:

Name: _____ **Dose:** _____

Prescriber: _____

Substances Used Past 12 Months:

- [ ] Alcohol
- [ ] Cannabis
- [ ] Opioids
- [ ] Benzodizepines
- [ ] Stimulants
- [ ] Tobacco/Vape
- [ ] Other

Notes:

Drug of Choice: _____

Consequences of Use:

- [ ] Legal
- [ ] Medical
- [ ] Social
- [ ] Overdose

Periods of Sobriety:

Family History of Substance Use:

Check all criteria present:

- [ ] Loss of control
- [ ] Craving
- [ ] Social/interpersonal problems
- [ ] Tolerance
- [ ] Time spent obtaining/using
- [ ] Continued use despite harm
- [ ] Unsuccessful attempts to cut down
- [ ] Failure in roles
- [ ] Risky use
- [ ] Withdrawal
- [ ] Giving up activities

Severity:

○ Mild (2-3) ○ Moderate (4-5) ○ Severe (6+)

Condom Use:

○ Always ○ Sometimes ○ Never

Sex under influence: _____ Partner w/ HIV/HepC: _____

IV Drug Use: _____ Shared equipment: _____

Referrals:

- [ ] HIV Test
- [ ] Hepatitis C Test
- [ ] STD Panel

Family of Origin:

Mother: _____ Father: _____

Siblings: _____ Quality of relationships: _____

Support System: _____ Children: _____

Name / Age:

Trauma History:

- [ ] Physical
- [ ] Emotional
- [ ] Sexual
- [ ] Neglect
- [ ] Witnessed Violence
- [ ] Other

Developmental Milestones:

- ◯ Normal
- ◯ Delayed

Select applicable:

- ◯ None
- ◯ Past Charges
- ◯ Probation/Parole
- ◯ Court involvement
- ◯ Custody involvement

Current Legal Situation:

Highest Education Level: _____ Employment Status: _____

Current Employer: _____ Work Functioning: _____

Financial Stress Impact on Recovery:

Have you used alcohol or drugs in the past 7 days? What and how much?: When was your last use?: _____

Have you ever had withdrawal symptoms (shakes, nausea, sweating, anxiety, hallucinations)?:

Any history of withdrawal seizures or DTs?:

Are you currently in withdrawal?: _____

Have you needed medical detox before?: _____

Risk Rating: _____

Do you have any ongoing medical conditions?: _____

Any chronic pain? Injuries?: _____

Any hospitalizations in the last year?: _____

Any prescribed medications?: _____

Any seizures unrelated to withdrawal?: _____

Last physical exam?: _____

Do you need medical attention today?: _____

Risk Rating: _____

Any depression, anxiety, hopelessness?: _____

Any bipolar, PTSD, OCD, psychosis history?: _____

Thoughts of harming self or others?: _____

Any recent emotional crises?: _____

Problems concentrating or thinking clearly?: _____

Do MH symptoms worsen with substances?: _____

Do you have a MH provider?: _____

Risk Rating: _____

What brings you here today?

Do you believe your substance use is a problem?: _____

Readiness to change?: _____

Any external pressure (court/family)?: _____

Goals for recovery?: _____

What might block progress?: _____

Risk Rating: _____

Last relapse?: _____

What triggers your use?: _____

Any cravings interfering with life?: _____

Any overdoses?: _____

Confidence in sobriety?: _____

Do you have coping skills?: _____

Access to substances at home?: _____

Risk Rating: _____

Where are you living? Is it stable?: _____

Are housemates supportive?: _____

Are substances present in the home?: _____

Sober supports?: _____

Financial stress?: _____

Relationship conflict?: _____

Do you feel safe?: _____

Risk Rating: _____

ASAM Recommended Level:

- ◯ Outpatient (1.0)
- ◯ Intensive Outpatient (2.1)
- ◯ PHP (2.5)
- ◯ Residential
- ◯ Other

Clinical Rationale:

Client Signature:

Date: _____ dd / mm / yyyy

Clinician Signature:

Date: _____ dd / mm / yyyy

Supervisor Signature (if required):

Date: _____ dd / mm / yyyy