Biopsychosocial History

DEMOGRAPHIC INFORMATION

[ClientInfo]: _____

BIOPSYCHOSOCIAL HISTORY

Please share what issue(s)/challenge(s) led you to seek counseling. How long have you been experiencing the issue/symptoms?

Passive Suicidal Ideation

◯ Yes ◯ No ◯ Unsure

Active Suicidal Ideation

◯ Yes ◯ No ◯ Unsure

Self-Harm

◯ Yes ◯ No ◯ Unsure

Dissociative Symptoms

◯ Yes ◯ No ◯ Unsure

Flashbacks

◯ Yes ◯ No ◯ Unsure

Paranoia

◯ Yes ◯ No ◯ Unsure

Delusions

◯ Yes ◯ No ◯ Unsure

Panic/Anxiety Attacks

◯ Yes ◯ No ◯ Unsure

Feeling Sad, Helpless, Depressed

◯ Yes ◯ No ◯ Unsure

Mood Swings

◯ Yes ◯ No ◯ Unsure

Obsessions or Compulsions

◯ Yes ◯ No ◯ Unsure

Anger

◯ Yes ◯ No ◯ Unsure

Impulsivity

◯ Yes ◯ No ◯ Unsure

Trouble Sleeping

◯ Yes ◯ No ◯ Unsure

Food and/or Body Image Struggles

◯ Yes ◯ No ◯ Unsure

Excessive worrying/rumination

◯ Yes ◯ No ◯ Unsure

Poor concentration/focus

◯ Yes ◯ No ◯ Unsure

Low Self-Esteem

◯ Yes ◯ No ◯ Unsure

Isolation/Withdrawn

◯ Yes ◯ No ◯ Unsure

Grief/Bereavement

◯ Yes ◯ No ◯ Unsure

Breakup/Divorce

◯ Yes ◯ No ◯ Unsure

Relationship Challenges (Familial/Friend/Romantic)

◯ Yes ◯ No ◯ Unsure

Recent addition of a child/birth of a child by myself or partner

◯ Yes ◯ No ◯ Unsure

Misuse/Dependence/Abuse of Alcohol

◯ Yes ◯ No ◯ Unsure

Misuse/Dependence/Abuse of Drugs

◯ Yes ◯ No ◯ Unsure

Persistent Fear of Abandonment

◯ Yes ◯ No ◯ Unsure

Avoidance of Triggers

◯ Yes ◯ No ◯ Unsure

Physical Abuse

☐ Yes
☐ No
☐ Unsure
☐ Childhood
☐ Adulthood

Physical Neglect

☐ Yes
☐ No
☐ Unsure
☐ Childhood
☐ Adulthood

Emotional Neglect

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Emotional/Verbal Abuse

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Financial Exploitation

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Sexual Exploitation

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Sexual Abuse/Molestation

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Domestic Violence

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Witnessing Violence

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Immigration Trauma

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Racial Trauma

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Generational Trauma

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Other

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Childhood
- [ ] Adulthood

Have you had prior outpatient psychotherapy/counseling?

◯ Yes ◯ No ◯ Unsure

Has any family member had outpatient psychotherapy/counseling?

◯ Yes ◯ No ◯ Unsure

Have you had inpatient treatment for a psychiatric, emotional, or substance use disorder?

◯ Yes ◯ No ◯ Unsure

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?

◯ Yes ◯ No ◯ Unsure

Have you had any prior or current psychotropic medication usage?

◯ Yes ◯ No ◯ Unsure

Has any family member used psychotropic medications?

◯ Yes ◯ No ◯ Unsure

Name and Phone Number of Primary Care Physician: _____ **Name, Phone Number, and Email of Medication Prescriber (if any:**

List Name, Dosage, and Reason of all currently prescribed medications

List any known allergies

List any abnormal lab results and date of results

Is there a history of any of the following in the family (tuberculosis, birth defects, emotional problems behavior problems, thyroid problems, cancer, intellectual disability, heart disease, high blood pressure, alcoholism, drug abuse, diabetes, Alzheimer's disease/dementia, stroke, other chronic or serious health problems, or other medical conditions)

Date, Age and Reason for any serious hospitalizations or accidents

Consequences of substance abuse (Examples: hangovers, seizures, blackouts, overdose, withdrawal symptoms, medical conditions, tolerance, changes, loss of control, amount used, sleep disturbance, assaults, suicidal impulse, relationship conflicts, binges, job loss, arrests, other (list below)

Cancer

◯ Yes ◯ No ◯ Unsure

Mold Exposure

◯ Yes ◯ No ◯ Unsure

PANS Disease

◯ Yes ◯ No ◯ Unsure

Lead Poisoning

◯ Yes ◯ No ◯ Unsure

Autism Spectrum Disorder

◯ Yes ◯ No ◯ Unsure

Intellectual Disability

◯ Yes ◯ No ◯ Unsure

ADHD/ADD

◯ Yes ◯ No ◯ Unsure

Significant Injury

◯ Yes ◯ No ◯ Unsure

Chronic Health Problem

◯ Yes ◯ No ◯ Unsure

Delayed Development

◯ Yes ◯ No ◯ Unsure

Emotional/Behavioral Issues

◯ Yes ◯ No ◯ Unsure

Intellectual / academic functioning (examples: learning problems, authority conflicts, attention problems, mild intellectual disability, moderate intellectual disability, severe intellectual disability, current or highest education level and other)

Describe any other developmental problems or issues

Living situation (examples: housing adequate, homeless, housing overcrowded, dependent on others for housing, housing dangerous/deteriorating, living companions dysfunctional or other)

Education level: (Grade school, high school, some college, bachelors degree, masters degree, professional degree, trade school, or other - describe):

Employment situation, length of current employment and satisfaction level (describe):

Financial situation (describe):

Social support system (describe):

Military history (describe):

Legal history (describe including note if past or present situation):

Gender Identity: _____ Sexual Orientation: _____

Pronouns: _____ Sexual Satisfaction: _____

Neurodivergence: _____ Cultural Identity: _____

Other: _____

Sources of Data Provided Above (examples: Patient-self report for all, patient self report for some and caregiver/parent/guardian report for some , or other source [please identify].

What are your goals in treatment?

How will you know that you're making progress?