

# BIOPSYCHOSOCIAL HISTORY

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

Date: \_\_\_\_\_

**PRESENTING PROBLEMS**

What brings you into therapy today? \_\_\_\_\_

When did the problem arise? \_\_\_\_\_

**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		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	binging/purging	<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"/>
Appetite Disturbance	<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"/>	elevated mood	<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"/>	anorexia	<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"/>
Elimination Disturbance	<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"/>	dissociative states	<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"/>						somatic complaints	<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"/>	loose associations	<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"/>
Poor concentration	<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"/>	weight gain/loss	<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"/>	hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	medical conditions	<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"/>	aggressive behaviors	<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"/>
Agitation	<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"/>	physical trauma victim	<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"/>	oppositional behavior	<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"/>
Irritability	<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"/>	substance abuse	<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"/>	grief	<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"/>
Panic attacks	<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"/>					
Phobias	<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"/>					
Obsessions/compulsions	<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"/>					

**EMOTIONAL/PSYCHIATRIC HISTORY**

Prior suicide attempts?

No Yes If yes, when? \_\_\_\_\_

Circumstances that led to the attempt: \_\_\_\_\_

Current suicidal thoughts?

No Yes If yes, describe: \_\_\_\_\_

Prior outpatient psychotherapy?

No Yes If yes, on \_\_\_\_\_ occasions. Longest treatment by \_\_\_\_\_ for \_\_\_\_\_ sessions from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____

Has any family member had outpatient psychotherapy? If yes, who/why (list all): \_\_\_\_\_

No Yes \_\_\_\_\_

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

No Yes If yes, on \_\_\_\_\_ occasions. Longest treatment at \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____

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? If yes:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

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

No Yes \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

**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"/>

**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  
your age at mothers death \_\_\_\_\_
- father deceased for \_\_\_ years  
your age at father's death \_\_\_\_\_

**Describe parents:**

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

**Describe childhood family experience:**

- outstanding home environment
- normal home environment
- chaotic home environment
- witnessed physical/verbal/sexual abuse toward other
- witnessed physical/verbal/sexual abuse from others

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

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 relationships
- currently in 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 your household:**

Name	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 you)**

Describe your current physical health:  Good  Fair  Poor

**List name of primary care physician:**

Name \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name \_\_\_\_\_ Phone: \_\_\_\_\_

**List any 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"/> behavioral problems                      | <input type="checkbox"/> drug abuse                    |
| <input type="checkbox"/> emotional problems                       | <input type="checkbox"/> alcoholism                    |
| <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 | _____  |

Name \_\_\_\_\_

Date \_\_\_\_\_

**SUBSTANCE USE HISTORY** (check all that apply for you)

**Family alcohol/drug abuse history:**

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

**Substances used:**

(complete all that apply)	First usage	Last usage	Current use (Yes/No)	Frequency	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 (LSD)	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (glue, gas)	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana or hashish	_____	_____	_____	_____	_____
<input type="checkbox"/> nicotine/cigarettes	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____	_____
<input type="checkbox"/> prescription _____	_____	_____	_____	_____	_____
<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

**Treatment history:**

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

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

- hangovers  withdrawal symptoms  sleep disturbance  binges
- seizures  medical conditions  assaults  job loss
- blackouts  tolerance changes  suicidal impulse  arrests
- overdose  loss of control amount used  relationship conflicts
- other \_\_\_\_\_

**SOCIO ECONOMIC HISTORY** (check all that apply for you)

**Living situation:**

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous
- problems with living companions

**Social support system:**

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

**Sexual history:**

- heterosexual orientation  currently sexually dissatisfied
- homosexual orientation  currently sexually satisfied
- bisexual orientation  currently sexually active
- sexual problems \_\_\_\_\_

**Employment:**

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- supervisor conflicts
- unstable work history
- disabled: \_\_\_\_\_

**Financial situation:**

- no current financial problems
- large amounts of debt
- poverty or below poverty line
- impulsive spending
- relationship conflicts over spending

**Legal history:**

- no legal problems
- now on parole/ probation
- arrest(s) not substance related
- court ordered this treatment
- jail/prison \_\_\_\_\_ time (s)

What is your field of employment? \_\_\_\_\_

Name of Employer? \_\_\_\_\_

Highest level of education completed? GED High School Associates Degree Some College Four years College Masters Degree Ph. D. (Circle One)

Where did you attend school and what did you study? \_\_\_\_\_

**Cultural/spiritual/recreational history:**

Cultural identity (e.g. ethnicity, religion) \_\_\_\_\_

Describe any cultural issues that contribute to current problems: \_\_\_\_\_

Are you currently active in community/recreational activities? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

Do you exercise? Yes No Explain: \_\_\_\_\_

Thank You

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