New Haven Home Recovery, Inc.

Biopsychosocial Assessment

Client Code: _____ Assessment Date: _____

Program: SHP NHFP MP CW THP Other: _____ Admission Date: _____

Birth date: _____ Age: _____ Gender: _____ Race: _____

Ethnicity/Culture: _____ Language(s): _____

FAMILY AND SOCIAL HISTORY

Where were you born? _____ Where were you raised? _____

Who did you live with during your childhood? _____

_____

Describe your family and childhood, including birth order: _____

_____

Were you ever in DCF, foster care, or lived anywhere other than with your family? YES NO

Describe: _____

Were there any special circumstances that impacted your childhood (loss, neglect)? YES NO

Describe: _____

Relationship	Name	Gender	Age	Living?	Lives with you?	Relationship Quality
Mother						
Father						
Spouse/Partner						

Children						

Significant Others (Siblings, Grandparents, Step-relatives, half-relatives)

Relationship	Name	Gender	Age	Living?	Lives with you?	Relationship Quality

Describe your relationship with family members: _____

_____

_____

DCF Involvement: ☐Current ☐Past ☐None ☐N/A Describe: _____

Do you have any concerns about your children?_____

_____

Social Relationships and Support

Client Code_____

Marital Status: ☐SNM ☐Married ☐Divorced ☐Separated ☐Partnered ☐Widowed

Sexual Orientation: _____

Do you have a significant other? YES NO If so, how long? _____

Describe your relationship history: _____

_____

What is your definition of a close friend? _____How Many? _____

Describe who you rely on for support:_____

Is there a cultural belief that you identify with? YES NO_____

How important to you are religious or spiritual matters? ☐Not ☐Little ☐Moderate ☐Very

Do you practice an organized religion? YES NO _____

Were you raised within a religious or spiritual group? YES NO _____

Trauma and Loss History

Have you experienced something traumatic? YES NO

If yes, please describe: _____

Have you ever experienced abuse? YES NO If yes, please describe including ages:

Physical Abuse:_____

Verbal Abuse: _____

Emotional Abuse: _____

Sexual Abuse:_____

Have you ever perpetrated abuse? YES NO Describe:_____

Have there been significant losses in your life? YES NO

If yes, please describe: _____

Client Code_____

EDUCATIONAL AND WORK HISTORY

Years of Education: _____ ☐Diploma ☐GED ☐Degree: _____ Year: _____

Additional Education/Training: _____

Special Circumstances (special education, LD): _____

Military Experience? YES NO Combat Experience? YES NO Where? _____

Branch: _____ Discharge Date: _____

Type of Discharge: _____ Rank at Discharge: _____

Currently: ☐ FT ☐ PT ☐ Temp ☐Unemployed ☐Disabled ☐ Retired ☐ Student ☐Other

Plans to change employment status: _____

Job History

Dates of employment	Employer	Position	Reason for leaving

What is the best part about working? _____

Do you have any barriers to employment? _____

Monthly Income

TANF	SAGA	SSI	SSDI	Employment	Unemployment	Food Stamps	Child Support	Basic Needs	Other

Do you have any debt or back bills? YES NO

If yes, debtor and how much: _____

Client Code_____

Leisure and Recreational

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, church)

Activity	How often now?	How often in the past?

HOUSING HISTORY

Are you currently homeless? YES NO When did you become homeless? _____

Total episodes of homelessness? _____Past 3 years?_____

Where were you living before becoming homeless? _____

Why did you have to leave? _____

Have you ever held your own lease? YES NO When? _____

Have you ever been evicted? YES NO

If yes, when? _____ Was the court involved? YES NO

Have you ever lived in one of the following?

Location		Describe	Dates
Transitional or Supportive Housing Program	YES NO		
Shelter Plus Care / Section 8	YES NO		
Sober House	YES NO		

Have you ever stayed in the following places because you had no where else to go?

Location		Describe	Dates
Place not meant for human habitation	YES NO		

With friends or family	YES NO		
Hotel or motel	YES NO		
Homeless Shelter	YES NO		
Domestic Violence Shelter	YES NO		

What are your plans for housing? _____

Who do you plan to reside with? _____

LEGAL HISTORY:

Are you involved in any active cases or warrants? YES NO

If yes, indicate charge and court dates/location: _____

Are you on probation or parole? YES NO

If yes, indicate terms and officer: _____

Past Charges

Charge	Date	Location	Results

Have you ever been incarcerated? YES NO

If yes, indicate dates and charges: _____

MEDICAL AND PHYSICAL HEALTH

Health Insurance: ☐ None ☐ SAGA ☐ HUSKY ☐ Title 19 ☐ Medicare ☐ Private _____

Current medical conditions, including pregnancy: _____

_____

Client Code_____

Medications (not including HIV or psychiatric medications)

Name	Dosage	Reason	Name	Dosage	Reason

Do you take these medications as prescribed? YES NO

Serious medical conditions, hospitalizations, surgeries:_____

_____

Allergies: _____

Medical Provider: _____ Physician's Name:_____

	Date	Location	Results
Last Physical Exam			
Last Dental Visit			
Last Mammogram			
Last Gynecologist Exam			

Sexual Health

Are you sexually active? YES NO_ Do you have multiple partners? YES NO

Birth control/safe sex methods: _____

History of Sexually Transmitted Infections: _____

HIV/AIDS

☐HIV Negative ☐HIV + (Not AIDS) ☐AIDS ☐Unknown Date of Dx or last test:_____

If HIV positive, please complete the following section:

CD4: _____ Viral Load: _____ Date of last labs: _____

Client Code_____

Disclosure (including family members): _____

Are children aware? YES NO If yes, are they receiving services? YES NO

If yes, where? _____

Current risk reduction practices: _____

Opportunistic Infections: _____

HIV Treatment Provider:

Medication	Dosage	Date Started	Medication	Dosage	Date Started

Adherence: ☐Complete ☐ Medication Non-Compliant ☐ Failure to attend appointments ☐None

Coping: ☐Good ☐ Fair ☐ Poor

Describe: _____

ADDICTION

Have you ever gambled too much? YES NO

If yes, please describe: _____

Have you ever had a problem with shopping? (debt or spent money you did not have) YES NO

If yes, please describe: _____

Have you ever had an eating disorder? YES NO

If yes, please describe: _____

Client Code_____

SUBSTANCE USE HISTORY

Do you have a family history of substance use? YES NO

Who and what substance? _____

Substance	First Use	Last use	Amount/Type	Frequency	Tolerance	Withdrawal Sx
Nicotine					YES NO	YES NO
Alcohol					YES NO	YES NO
Marijuana					YES NO	YES NO
Cocaine/Crack					YES NO	YES NO
Heroin/Opiates/Rx					YES NO	YES NO
Amphetamines					YES NO	YES NO
Barbiturates/Benzos					YES NO	YES NO
Club Drugs					YES NO	YES NO
PCP/Meth					YES NO	YES NO
Inhalants					YES NO	YES NO
OTC/Other Rx					YES NO	YES NO

Substance Preference(s): _____

Agonist Treatment: ☐Current ☐History ☐N/A

☐Methadone _____ mg ☐Buprenorphine _____ mg ☐Antabuse

Current severity of use: ☐None ☐Misuse ☐Abuse ☐Dependence

Current length of abstinence: _____ Longest period of abstinence: _____

Recovery Stage: ☐Pre-Contemplation ☐Contemplation ☐Preparation ☐Action ☐Maintenance

How do you believe your substance use has affected your life? _____

_____

Describe where and when you use substances: _____

_____

Client Code_____

Describe any changes in your use patterns: _____

_____

What or who has helped you stop or limit your use? _____

_____

MENTAL HEALTH AND PSYCHIATRIC HISTORY

Do you have a family history of mental illness? YES NO

If yes, please describe: _____ ___

_____

Current mental health concerns: _____

_____

_____

Symptomology

Have you ever experienced hallucinations or delusions? YES NO

☐Visual ☐Auditory ☐Command Auditory ☐Tactile ☐Delusions

Describe:_____

Have you ever had anxiety, excessive worrying, and/or panic attacks? YES NO

Describe:_____

Have you ever had elevated mood, excessive energy, irritability? YES NO

Describe: _____

Have you ever had obsessions or compulsions that impacted your functioning? YES NO

Describe:_____

Have you ever had periods of sadness, crying spells, and/or loss of interest? YES NO

Client Code_____

Describe: _____

Sleep: ☐Normal ☐Restless ☐DFA ☐MNA ☐EMA Hours: _____

Appetite: ☐Normal ☐Increased ☐Decreased ☐Other: _____

Energy: ☐Normal ☐Increased ☐Decreased ☐Other:

Mental Health and Substance Abuse Treatment History

Date	Reason	Provider	Modality
Current			

Psychiatric Medications

Name	Dosage	Reason	Name	Dosage	Reason

Who prescribes your medications? _____

Do you ever miss doses? YES NO How often? _____

Have you ever taken more than prescribed? YES NO Which one? _____

Do you have any side effects? YES NO Describe: _____

Have you ever taken or been prescribed psychiatric medications in the past? YES NO

List: _____

Risk Assessment

Do you have a family history of suicide? YES NO

Client Code_____

Describe:_____

Do you ever think about suicide? YES NO

Describe:_____

Frequency: _____ (how often) Duration: _____ (for how long)

Do you have a plan to harm/kill yourself? YES NO

Describe:_____

Do you have a history of thinking about suicide? YES NO

Describe:_____

Do you have a history of suicide attempt(s)? YES NO

Describe:_____

Do you have a history of harming yourself (self mutilation)? YES NO

Describe:_____

Risk Factors: ☐Access to means ☐Impulsivity ☐Shame ☐Isolation ☐Rehearsal

Do you have a history of being violent or assaultive? YES NO

Describe:_____

Do you ever think about hurting or killing other people? YES NO

Describe:_____

Do you have a plan to harm someone? YES NO

Describe:_____

Is client in imminent danger of harming self or others? YES NO

Report made: YES NO Parties notified: _____

MENTAL STATUS

Client Code_____

Appearance: ☐Well-groomed ☐Disheveled ☐Bizarre/Inappropriate ☐Dirty/Odor ☐Other

Describe: _____

Alertness: ☐Alert ☐Drowsy ☐Restless/Fidgety ☐Lethargic ☐Hyper

Describe: _____

Attitude: ☐Cooperative ☐Guarded ☐Hostile/Challenging ☐Nervous ☐Uncooperative

Describe: _____

Affect: ☐Normal ☐Constricted ☐Flat ☐Euphoric ☐Irritable ☐Labile ☐Depressed

Describe: _____

Memory: ☐Intact ☐Distractible ☐Poor Short Term ☐Poor long term ☐Other

Describe: _____

Thought ☐Logical/Goal Oriented ☐Tangential ☐Circumstantial ☐Derailment ☐Blocking

Continuity: ☐Flight of Ideas ☐Other

Describe: _____

Thought ☐Appropriate ☐Obsessions ☐Delusions ☐Compulsions ☐Grandiose

Content: ☐Morbid ☐Preoccupations ☐Depersonalization

Describe: _____

Speech: ☐Normal ☐Rapid ☐Delayed/Slow ☐Slurred ☐Pressured ☐Dramatic ☐Other

Describe: _____

Oriented: ☐Person ☐Time ☐Place Disoriented to: _____

Eye Contact: ☐Normal ☐Avoids ☐None Describe: _____

Judgment: ☐Good ☐Fair ☐Poor Describe: _____

Insight: ☐Denial ☐Blames Self ☐Blames Others ☐Intellectual ☐Full Emotional

Describe: _____

Client Code_____

OBSERVATIONS, TARGET SYMPTOMS AND FUNCTIONAL ASSESSMENT

_____

_____

_____

PRELIMINARY DSM-IV DIAGNOSITIC IMPRESSION

Axis I _____

_____

_____

_____

Axis II _____

Axis III _____

_____

Axis IV _____

_____

Axis V MGAF _____

Recommendations

- _____
- _____
- _____
- _____

Client Code_____

- _____

Clinicians Signature _____ Date _____

Supervisors Signature _____ Date _____