



Biopsychosocial History & Assessment
Adult Self-Report (Part A)

Client Name: _____

Instructions: Please answer the following questions to the best of your ability, as this will be helpful to your therapist in better understanding your situation.

Name: _____ Age: _____ Date of Birth: _____

Racial Identity: (check all that apply)
 Native American or Alaskan Native Hispanic or Latino Native Hawaiian or Pacific Islander
 Asian or Asian American White Black or African American
 Other: _____

PRESENTING PROBLEM

Check if you are experiencing any of the following problems (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Family / Friends | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Marital / Relationships | <input type="checkbox"/> Physical health |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sexual issues / Orientation | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Eating habits | <input type="checkbox"/> Gambling issues |

We would appreciate learning more about you and your perspective on your life. Please describe, in detail, why you checked the above items. Tell us about your challenges, strengths, your needs and any family or community support you have in your life:

What goals would you like to accomplish in treatment:

1. _____

2. _____

3. _____

4. _____

SYMPTOM CHECKLIST

The following is a list of symptoms that have to do with various psychological problems. Please circle the number from zero (0) to four (4) that best describes how much this symptom or problem bothers you. Use the following scale:

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

In the past week, how much were you bothered by:	Not at all		Moderately		Extremely
1. Feeling depressed, sad, blue, down, unhappy most of the time	0	1	2	3	4
2. Feeling easily annoyed or irritated	0	1	2	3	4
3. Feeling no interest in things or avoiding enjoyable activities, family, or friends	0	1	2	3	4
4. Feeling tired all the time even with adequate sleep	0	1	2	3	4
5. Trouble concentrating: can't stay focused on activities	0	1	2	3	4
6. Feeling lonely even when you are with people	0	1	2	3	4
7. Feeling hopeless about the future	0	1	2	3	4
8. Significant increase or decrease in appetite or weight	0	1	2	3	4
9. Sleeping problems: can't fall asleep, restless sleep, sleeping too much	0	1	2	3	4
10. Thoughts of suicide: thinking "I wish I were dead," "life isn't worth living anymore"	0	1	2	3	4
11. Suicide attempt: intent or action to hurt or kill self with pills, weapons, cuts, etc.	0	1	2	3	4
12. Racing thoughts, rapid speech, little or no need for sleep, impulsive traveling and/or spending money	0	1	2	3	4
13. Doing things without thinking and often getting yourself into a jam	0	1	2	3	4
14. Feeling so restless you could not sit still	0	1	2	3	4
15. Feeling anxious: worrying excessively or worry about many things	0	1	2	3	4
16. Feeling tense or keyed up	0	1	2	3	4
17. Spells of terror or panic	0	1	2	3	4
18. Fearful feelings of being humiliated in social situations	0	1	2	3	4
19. Feeling uneasy in crowds or in open spaces	0	1	2	3	4
20. Feeling afraid to travel on buses, subways, trains, or planes	0	1	2	3	4
21. Feeling inferior to others	0	1	2	3	4
22. Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
23. Sudden re-experiencing of feelings, thoughts, images of a traumatic event	0	1	2	3	4
24. Temper outbursts that you could not control	0	1	2	3	4
25. Feeling "nothing" or numb, as if blocked as in taking a pain killer	0	1	2	3	4
26. Recurrent thoughts, impulses, or images that are intrusive and troubling	0	1	2	3	4
27. Excessive repeating of an activity that you couldn't resist even though it sometimes seems foolish (e.g., cleaning, washing hands, counting, etc.)	0	1	2	3	4
28. Feeling that you are watched or talked about by others	0	1	2	3	4
29. Seeing or hearing things outside yourself that others tell you are not really there	0	1	2	3	4
30. The idea that someone else can control your thoughts	0	1	2	3	4

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31. Feeling that most people cannot be trusted	0	1	2	3	4
32. Persistent fears about health problems despite doctors finding nothing wrong	0	1	2	3	4
33. Episodes of binge eating, purging/vomiting, or periods of not eating	0	1	2	3	4
34. Feeling others are to blame for most of your troubles	0	1	2	3	4
35. Having urges to break or smash things or injure someone	0	1	2	3	4
36. Getting into frequent arguments with family members, friends or co-workers	0	1	2	3	4
37. Difficulty managing children, feel parenting skills are deficient	0	1	2	3	4
38. Occupational concerns: job dissatisfaction, problems with employer/co-workers	0	1	2	3	4
39. Other:	0	1	2	3	4

For the next several questions, please circle the number that represents how frequently you use any of the following substances. Use the following scale:

0 = Never 1 = In past, not currently 2 = Monthly 3 = Weekly 4 = Almost daily

	Never	In Past	Monthly	Weekly	Daily
a.Caffeine: coffee, caffeinated beverages	0	1	2	3	4
b.Nicotine: cigarettes, cigars	0	1	2	3	4
c.Beer / Liquor	0	1	2	3	4
d.Marijuana, hash	0	1	2	3	4
e.Sedatives: tranquilizers, sleeping pills, barbiturates, valium, xanax, Quaaludes	0	1	2	3	4
f.Inhalents / Solvents: glue, toluene, gasoline	0	1	2	3	4
g.Stimulants: amphetamines, "speed", Ritalin	0	1	2	3	4
h.LSD, psychedelics, mescaline, peyote, DMT, ecstasy	0	1	2	3	4
i.Cocaine / Crack / Crank, coca leaves	0	1	2	3	4
j.Opioids: herion, codeine, Demerol, morphine, percodan, methadone, darvon, oxycodone	0	1	2	3	4
k.PCP, "angel dust"	0	1	2	3	4
l.Other:	0	1	2	3	4

PSYCHOLOGICAL HISTORY

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? Yes No
 If yes, what and when: _____

Have you ever been in counseling or psychotherapy before? Yes No
 If yes, where and when: _____

Have you had any past hospitalizations for emotional problems? Yes No
 If yes, when and where: _____

Have you ever intentionally hurt yourself or made a suicide attempt? Yes No
 If yes, explain how and when: _____

MEDICAL HISTORY

Check if you are currently experiencing or have ever experienced:

- | | | |
|--|---|---|
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma or hay fever |
| <input type="checkbox"/> Heart (trouble, disease, surgery) | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney or bladder problems | <input type="checkbox"/> Weight change/change in appetite |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Glaucoma/Cataracts |
| <input type="checkbox"/> Rheumatic fever or heart disease | <input type="checkbox"/> Jaundice/rashes/sores | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Abnormal blood pressure | <input type="checkbox"/> Hepatitis – type A B C | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Ulcers/abdominal pain | <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> HIV positive / AIDS / ARC |
| <input type="checkbox"/> Epilepsy (Seizure Disorder) | <input type="checkbox"/> Hemophilia/blood disease | <input type="checkbox"/> Hearing impaired |
| <input type="checkbox"/> Tuberculosis or lung disease | <input type="checkbox"/> Sickle Cell disease | <input type="checkbox"/> Visual problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Cancer / tumors | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Other _____ |

If you checked any of the above medical items, please explain:

Are you currently experiencing any physical pain? Yes No
 If yes, where is the pain: _____

Are you currently receiving care for your pain? Yes No
 By whom: _____

Do you have any allergies or reactions to medication? Yes No
 If yes, what medications: _____

Who is your primary care physician: _____

Are you taking any prescribed medications? Yes No

Name of medication	Dosage and Frequency	Reason	Physician

Please indicate any herbal or homeopathic substances that you are currently taking: _____

FAMILY HISTORY

Please list Parents, Siblings, Spouse/Partner, Children, and Significant Relatives/Others:

Name (First & Last)	Relationship	Age	School / Occupation	City of Residence

How many pregnancies have you experienced? _____

Marital Status: Never married Long-term relationship Married Divorced Separated Widowed

Number of marriages: _____ If married, how long? _____

If past divorce, when and why? _____

Who currently lives in your household? _____

Is there a history of depression, anxiety, alcoholism, or other mental health conditions in your family? Yes No
 If yes, who? What was the problem? Did they receive treatment or medication? _____

Have you ever experienced any emotional, physical, or sexual abuse? Yes No
 If yes, please explain: _____

Have you ever been accused of assaulting or inappropriately touching someone? Yes No
 If yes, please explain who / when: _____

Does the use of alcohol or drugs by someone close to you contribute to your problems? Yes No
 If yes, please explain: _____

Did you grow up in a home in which a parent abused alcohol or drugs? Yes No

EDUCATIONAL & VOCATIONAL HISTORY

What is your highest grade level completed? _____ Do you have a GED in lieu of diploma? Yes No

How did you do academically in school? _____

How was your conduct throughout school? _____

If attended college, where and what is your degree? _____

What is your occupation / job? _____ For how long? _____

Have you ever been fired? Yes No If yes, explain: _____

Do you have any current financial problems? Yes No If yes, explain: _____

Do you have any language or reading difficulties? Yes No If yes, explain: _____

MILITARY HISTORY

Did you ever serve in the military? Yes No Branch of Military: _____

Date / Type of Discharge: _____ Do you have any combat history? Yes No

LEGAL HISTORY

Do you have a legal history consisting of past or current:

Arrests Yes No Explain: _____

Restraining Order Yes No Explain: _____

Divorce / Custody Yes No Explain: _____

Incarceration Yes No Explain: _____

Probation Yes No Explain: _____

CULTURAL / RELIGIOUS / SPIRITUAL HISTORY

What is your ethnic or cultural heritage? _____

In what religion did you grow up? _____ Your current religion? _____

How does your ethnicity or religious beliefs influence your life? _____

Signature of person completing this form: _____ Date _____