ADULT BIOPSYCHOSOCIAL SCREENING	**Today's Date:**
	DOB:

1. IDENTIFYING INFORMATION	
Client Name:	Availability:
Home Phone: Can we leave a message: ☐ Yes ☐ No	Cell Phone: Can we leave a message: ☐ Yes ☐ No Can we contact you by text: ☐ Yes ☐ No
Email _____ Can we communicate billing issues: ☐ Yes ☐ No	Video capability: Skype Face Time Other: _____

2. RACE/ETHNICITY/FAMILY OF ORIGIN:
Examples Include…Black, African, Haitian, Caucasian, Cuban, Mexican, Puerto Rican, Asian, American Indian, Alaska Native, Chinese, Indian, Japanese, Korean, Malaysian, Pakistan, Philippine, Taiwanese, Vietnamese, Hawaiian, Samoan, Pacific Islander, Guatemalan

RELIGION:

MARITAL STATUS

☐ Single ☐ Married/Civil Union ☐ Separated ☐ Divorced ☐ Cohabitating/Partnered ☐ Widowed ☐ Remarried

3. EDUCATIONAL HISTORY

Are you currently pursuing schooling? ☐ Yes ☐ No If yes, where:

What is your highest grade completed? When:

Did you have any special education circumstances (e.g. learning disabilities, gifted program, special education classes, etc.)

4. EMPLOYMENT/VOCATIONAL HISTORY

Are you currently employed? ☐ Yes ☐ No Length of employment: Employed as:

How many times have you changed jobs and reasons:

Any special circumstances related to employment (e.g. recently lay off, self-employed, suspended, disabled, injured, retired, etc.)?

5. LEISURE/RECREATIONAL HISTORY

Describe any special interests or hobbies you may have (art, music, crafts, outdoor activities, church, sports):

Has your activity level changed recently? ☐ Yes ☐ No If yes, please explain:

6. FAMILY INFORMATION

Family Member	First Name	Issues with Family Members	Age	Lives with you	
				Yes	No
Mother		☐ Physical ☐ Mental ☐ Addiction			
Father		☐ Physical ☐ Mental ☐ Addiction			
Siblings		☐ Physical ☐ Mental ☐ Addiction			
		☐ Physical ☐ Mental ☐ Addiction			
		☐ Physical ☐ Mental ☐ Addiction			
		☐ Physical ☐ Mental ☐ Addiction			
Spouse/ Partner		☐ Physical ☐ Mental ☐ Addiction			
Children		☐ Physical ☐ Mental ☐ Addiction			
		☐ Physical ☐ Mental ☐ Addiction			
		☐ Physical ☐ Mental ☐ Addiction			
		☐ Physical ☐ Mental ☐ Addiction			

7. PRIOR TREATMENT AND COUNSELING HISTORY

Have you ever had outpatient counseling before? ☐ Yes ☐ No

Have you ever been in a higher level of care? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Have you ever been treated for a substance use problem? ☐ Yes ☐ No

Reason for Treatment	Where	When	Was it helpful?
			☐ Yes ☐ No

8. HEALTH ASSESSMENT AND PHYSICIAN INFORMATION		
Date of last complete physical exam:	Date of last visit to physician:	New physical required: ☐ Yes ☐ No
Primary Care Physician Phone Number Address		
Gynecologist Phone Number Address		
Psychiatrist/APN Phone Number Address		

Please Circle any Relevant Health Information Below:

Fatigue	Loss or abnormal sensation	Smoke cigarettes
Vision (glasses, etc.)	Nausea, vomiting, diarrhea	Paralysis
Sexual problem	Heart palpitations	Chest pain
Teeth Problems	Persistent Headaches	Allergies (sneezing, runny nose)
Hearing Problems	Rash (identify location)	Skin lesion that won't heal
Sinuses (sleep apnea, etc.)	Burning, frequent urination, incontinence	Chronic Pain

1. Do you have any chronic medical conditions? YES_____ NO_____
   (Diabetes, HBP, Heart Condition, Thyroid)
2. Do you have any infectious disease? YES_____ NO_____
   (HIV/AIDS, Tuberculosis, Hepatitis)
   a. Do you have a cough that won't go away? YES_____ NO_____
   b. Do you cough or spit up blood? YES_____ NO_____
   c. Do you have night sweats or fever? YES_____ NO_____
3. Do you have an eating disorder? YES_____ NO_____
4. Do you Experience difficulty chewing/swallowing? YES_____ NO_____
5. Any food intolerance or special diet? YES_____ NO_____
6. Any food or drug allergies? YES_____ NO_____
7. Weight gain/loss more than 10 lbs in 3 months? YES_____ NO_____
8. Do you carry an EpiPen? YES_____ NO_____

Any family history of (circle): Type 2 Diabetes Hypertension Cardiovascular Disease

9. MEDICATIONS

Are you currently taking any prescribed medications? ☐ Yes ☐ No

Medication	Amount	Frequency	Reason	Side Effects

Are you currently taking any over the counter or herbal medications? ☐ Yes ☐ No
If yes, please list

Do you have any drug allergies? ☐ Yes ☐ No
If yes, please specify:

General allergies? ☐ Yes ☐ No
If yes, please list

10. NUTRITIONAL SCREENING

Weight	Height	Have you had any recent weight changes? ☐ Yes ☐ No If yes, please explain:

☐ Medical problems requiring special diet ☐ Use of diet pills, laxatives, diuretics, forced vomiting ☐ Restriction of food intake &/or eating more than planned ☐ There is a need for dietary consult currently ☐ Client denies the above	Please elaborate on any checked boxes:

11. DRUG/ALCOHOL HISTORY Complete table below

SUBSTANCE	Denies	Age of Onset	Amount Used	Frequency of Use	Duration	Date of Last Use	Method of Use
Alcohol							
Barbiturates							
Valium/Librium/Xanax, etc.							
Cocaine/Crack							
Amphetamines							
Heroin/Opiates							
Marijuana							
PCP/LSD/Mescaline							
Inhalants							
Caffeine							
Nicotine							
Over-the-counter (Identify)							
Prescription Drugs (Identify)							
Other Drugs (Identify)							

Symptoms of drug/alcohol withdrawal	☐ Shakes ☐ Convulsions	☐ Hallucinations ☐ Blackouts/ memory lapses	☐ Other:
Changes in use and tolerance			
Pattern of use	☐ Continuous ☐ Episodic	☐ Binge ☐ Other:	Longest length of abstinence:
History of relapse			
Consequences of use			
Gambling or other addictive behavior			

Do you consider yourself to have a substance abuse problem? ☐ Yes ☐ No

12. LEGAL HISTORY
1. Have you been involved in any active legal cases? custody, divorce, domestic violence complaint, restraining order, arrest, conviction, incarceration, victim of a violent crime, DWI, DUI ☐ Yes ☐ No ☐ Current (If current, you MUST provide documentation IF relevant to your treatment) ☐ Past If you are here to follow up on an IDRC referral please indicate the location you completed the hours: If yes, briefly state charges, hearing date/trial. outcome:
2. Are you presently on probation or parole? ☐ Yes ☐ No If yes, please explain and list name and contact number of parole/probation officer:

13. MILITARY HISTORY
Were you ever or are you currently in the military? ☐ Yes ☐ No Years Serving: If yes, branch:
Combat experience: ☐ Yes ☐ No Where:
Type of Discharge:

14. PRIORITIES OF THERAPY
Below, please list by priority goals you wish to accomplish in therapy and review with your therapist
Priority Focus 1:
Priority Focus 2:
Priority Focus 3:

Client Signature: _____ Date: _____

Clinician Review: _____ Date: _____

Revised 04/19