BioPsychoSocial/Spiritual Integrated Screening/Assessment Intake

Client First, Middle Initial, Last Name: | Date:

Address, City, State, Zip: | Age: | Sex:

Marital Status: ☐Married ☐Divorced ☐Separated ☐Legally Separated ☐Unmarried ☐Widowed ☐Registered Domestic Partner

Date of Birth: | Birthplace: | Race/Ethnicity: | SSN:

Preferred Phone#(s):(#1)(____) ☐home/☐work/☐cell | (#2)(____) ☐home/☐work/☐cell

May I leave messages? ☐#1 ☐#2; Text? ☐#1 ☐#2 | May I email? ☐ No ☐ Yes Email address:

Insurance Program/Plan (Provide **card)**: | ID#: | Group/FECA#:

Employer/School: | Address, City, State, Zip:

Client Employer/School Phone: | Occupation: | ☐Full ☐Part Time?

Active Military *USA*☐ServiceMember☐FamilyMember *Overseas*☐SM☐FM ☐Leave of absence ☐Retired ☐Terminated

Check one: ☐FT student ☐PT student ☐Not student | Prior Authorization Number:

Other health insurance (Member name, policy/group#, DOB, Sex, Employer/School, Ins Plan, relationship to insured, type, SSN, carrier Name, carrier ID):

IF NOT SELF; Sponsor/Insured's First, Middle Initial, Last Name:

Address, City, State, Zip ☐SAA/: | Sex:

Sponsor SSN: | Phone: | DOB:

Insured's Employer/School: | Insured's Employer/School Phone:

Address, City, State, Zip: | ☐Full ☐Part Time?

Occupation: | Relationship to Client:

Emergency Contact Name: | Phone: | Address:

Primary Care Physician/PCM: | Phone: | Address:

Hospital Name: | Phone: | Address:

Other current provider(s): | Could we coordinate care? ☐No ☐Yes, Phone:

Previous practitioners and treatment dates: | Therapeutic interventions and responses: What was/was not helpful about it?

Medication(s) Name, Dosage, Purpose: | Initial Rx date, refill dates:

Prescribing Physician: | Are you using them as prescribed? ☐No ☐Yes

Medical conditions: | Advanced Health Care Directive? ☐No ☐Yes: ☐DNR

Current height: | Weight: | Any accidents especially head trauma:

Laboratory results: | Psychological test results:

Consultation reports: | Allergies/Sensitivities:

Did someone refer you? ☐No (how practice found): ☐ Yes, who:

Therapy goal: | Who you want to attend therapy with you:

Any **problems** with: ☐anger/aggression ☐anxiety ☐appetite ☐cognitive/learning impairment ☐decreased energy ☐delusions/psychosis ☐depression ☐dissociation ☐homicidal thoughts ☐elevated mood/mania ☐hallucinations ☐hopelessness ☐helplessness ☐hyperactive ☐impulsivity/reckless ☐insight/judgment ☐obsessions/compulsions ☐oppositional defiance ☐orientation/memory problems ☐panic attacks ☐paranoia ☐poor concentration/attention ☐comprehension ☐conversation ☐mobility ☐pressured speech ☐severe mood swings ☐sleep disturbance ☐somatic complaints ☐agitation ☐irritability ☐disorganized speech ☐ADLs ☐Assertiveness ☐Sadness ☐Gambling ☐Grief/loss ☐Job/School/Home work Performance ☐Loneliness ☐Shyness ☐Guilt ☐Self-esteem ☐Thoughts ☐Nightmares ☐Stress ☐Self-harm ☐Friends/Social/Relationships ☐Family ☐Parents ☐Past events ☐Divorce ☐Separation ☐Marriage ☐Premarital ☐Dating ☐Miscarriage ☐Abortion ☐In-laws ☐Infertility ☐Parenting ☐Infidelity ☐Sexuality ☐Gender Identity ☐Sex addiction ☐Eating disorder ☐Financial ☐Housing ☐Culture ☐Language ☐Personality ☐Community ☐Insecurity ☐Trauma ☐Fears:

When did you first experience symptoms related to this visit?

Strengths: | Weaknesses:

Spiritual/religious/sacred beliefs/stressors:	Interests/hobbies/activities:
What sustains you in difficult times?	What would you like your legacy to be?
Who is important in your life?	
Education history:	Occupational history:
Have you experienced **physical** violence? □ No □ Yes (event, when, response):	
Have you experienced **verbal** abuse? □ No □ Yes:	
Have you ever seriously contemplated suicide? □No □Yes (when):	Suicide attempted? □No □Yes: #attempts, dates:
Current suicidal ideation? □Never □Sometimes □Often □Daily; Imminent risk of harm/elopement potential: □No □Yes:	
Psychiatric hospitalization #, Dates, Diagnosis, Treatment:	
Legal history: □DHS Income Supports/□Child Protection, □Youth Diversion, □Criminal Justice/□Probation, □Substance Abuse Arrests and/or □Treatment, □Domestic Violence Intervention Victim Services/□Offender Treatment, □Veteran's Services, □Corrections History/□Parole/□Community Corrections/□Reentry, □Foster Care:	

Family History

Members/Pets of Household: Name	Age	Gender	(Biological, adopted, foster, step, etc.)? Special needs?

Do you have family members not currently living with you? □No □Yes; How often do you see them or contact them?

Name	Age	Gender	Relation(Biological,adopted,foster,step, etc.)	Location

Partner’s occupation:	Length of relationship:
Describe your partner’s personality:	
How do you resolve conflicts or differences?	

If previously married, please complete the following:		
1st marriage: Date married:	Date ended:	Ex-spouse’s name:
Children: □ Yes □ No	Reason for divorce:	
2nd marriage: Date married:	Date ended:	Ex-spouse’s name:
Children: □ Yes □ No	Reason for divorce:	

Father □ Living, Age:	Occupation:	Health:
□ Deceased, Cause:		Your age at the time of his death:
Describe your father’s personality:		
Mother □ Living, Age:	Occupation:	Health:
□ Deceased, Cause:		Your age at the time of her death:
Describe your mother’s personality:		
Brothers:		Ages:
Sisters:		Ages:
Describe your relationship with your brothers and sisters:		
Describe your childhood home atmosphere:		

Religious or cultural/ethnic upbringing: (More positive or negative? CIRCLE)

If not raised by your parents, who did, and when?

Family members with Alcohol/Substance abuse □No □Yes:
Family members with serious medical health conditions, i.e. epilepsy □No □Yes (who has what?):
Family members with a mental health diagnosis? □No □Yes:

Developmental history (physical, psychological, social, intellectual, academic): Delayed/Normal/Early

Prenatal and perinatal events: Premature/Complications/Healthy/Natural/C-section/Problems:

Health problems during childhood/adolescence:

List Illnesses/hospitalizations/surgery dates/reason:

Alcohol: □ Abstinent □Daily □Weekly □Monthly x _____ # Years/Mos Quantity:______ Age First Used: _____
Date Last Use:

Tobacco: □ Abstinent □Daily □Weekly □Monthly x _____# Years/Mos Quantity:______ Age First Used:_____
Date Last Use:

Caffeine: □ Abstinent □Daily □Weekly □Monthly x _____ # Years/Mos Quantity:______ Age First Used:_____
Date Last Use:

<u>History(underline</u>)/Current(circle) □None □Yes: Marijuana/synthetic, Cocaine, LSD, Prescription/OTC Drugs, Crystal Meth, Heroine, Ecstasy, Other: ____________________ □Daily □Weekly □Monthly x ________
Years/Mos Quantity:______ Age First Used:_____ Date Last Use:

Have you been arrested for driving under the influence? □No □Yes Date(s):

Has anyone said your use is a problem? □No □Yes(who, when, how, what happened):
How does your personality change when using:

Has your behavior become more hostile or conflicted under the influence of drugs/alcohol? □No □Yes

Have you had times you cannot remember, the day after you used drugs/alcohol? □No □Yes How often?

Have you received substance abuse treatment? □No □Yes, Dates, Where, Outcome:
Have you tried to quit? □No □Yes, Outcome:

Does your use cause harm to self or others? □No □Yes(who, how):
Are you considering screening this as a goal? □No □Yes:

Have you become restless, irritable or anxious when trying to stop/cut down on gambling? □No □Yes
Have you ever tried to keep your family or friends from knowing how much you gambled? □No □Yes
Have you had such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare? □No □Yes

Are you sexually active?	□Yes (age you first become sexually active): Is your present sex life satisfactory? □Yes □No (problems: addictions, anxiety, guilt, low desire, high desire, lacks emotional intimacy, etc.): Is this a goal? □No □Yes(specify):
□ No	

Do you often find yourself preoccupied with sexual thoughts? □Yes □No

Do you hide your sexual behavior? □Yes □No

Have you ever sought help for sexual behavior you did not like? □Yes □No

Has anyone been hurt emotionally from your sexual behavior? □Yes □No

Do you feel controlled by your sexual desires? □Yes □No

When you have sex, do you feel depressed afterwards? □Yes □No

Have you experienced sexual abuse?(*fondling, inappropriate remarks, witnessing adults display sexual behavior, lack of privacy in home, coercion by adults to participate in sexual games, being "checked out" to see if you are developing "properly", having sex, or intrusive touching etc.)* □No □Yes; Abuser alive? □No □Yes; Person of trust now? □ No □ Yes; Report#: