

### BioPsychoSocial/Spiritual Integrated Screening/Assessment Intake

Client First, Middle Initial, Last Name:			Date:		
Address, City, State, Zip:			Age:		Sex:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unmarried <input type="checkbox"/> Widowed <input type="checkbox"/> Registered Domestic Partner					
Date of Birth:		Birthplace:		Race/Ethnicity:	
SSN:		Preferred Phone#(s): (#1)( ) <input type="checkbox"/> home/ <input type="checkbox"/> work/ <input type="checkbox"/> cell (#2)( ) <input type="checkbox"/> home/ <input type="checkbox"/> work/ <input type="checkbox"/> cell			
May I leave messages? <input type="checkbox"/> #1 <input type="checkbox"/> #2; Text? <input type="checkbox"/> #1 <input type="checkbox"/> #2			May I email? <input type="checkbox"/> No <input type="checkbox"/> Yes		Email address:
Insurance Program/Plan (Provide card):			ID#:		Group/FECA#:
Employer/School:			Address, City, State, Zip:		
Client Employer/School Phone:			Occupation:		<input type="checkbox"/> Full <input type="checkbox"/> Part Time?
Active Military <i>USA</i> <input type="checkbox"/> ServiceMember <input type="checkbox"/> FamilyMember <i>Overseas</i> <input type="checkbox"/> SM <input type="checkbox"/> FM <input type="checkbox"/> Leave of absence <input type="checkbox"/> Retired <input type="checkbox"/> Terminated					
Check one: <input type="checkbox"/> FT student <input type="checkbox"/> PT student <input type="checkbox"/> 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):					
<b>IF NOT SELF; Sponsor/Insured's First, Middle Initial, Last Name:</b>					
Address, City, State, Zip <input type="checkbox"/> SAA/:					Sex:
Sponsor SSN:		Phone:		DOB:	
Insured's Employer/School:			Insured's Employer/School Phone:		
Address, City, State, Zip:					<input type="checkbox"/> Full <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Medical conditions:					
Current height:		Weight:		Any accidents:	
Laboratory results:			Psychological test results:		
Consultation reports:			Allergies/Sensitivities:		
Did someone refer you? <input type="checkbox"/> No (how practice found):				<input type="checkbox"/> Yes, who:	
<b>Therapy goal:</b>			Who you want to attend therapy with you:		
Any <b>problems</b> with: <input type="checkbox"/> anger/aggression <input type="checkbox"/> anxiety <input type="checkbox"/> appetite <input type="checkbox"/> cognitive/learning impairment <input type="checkbox"/> decreased energy <input type="checkbox"/> delusions/psychosis <input type="checkbox"/> depression <input type="checkbox"/> dissociation <input type="checkbox"/> homicidal thoughts <input type="checkbox"/> elevated mood/mania <input type="checkbox"/> hallucinations <input type="checkbox"/> hopelessness <input type="checkbox"/> helplessness <input type="checkbox"/> hyperactive <input type="checkbox"/> impulsivity/reckless <input type="checkbox"/> insight/judgment <input type="checkbox"/> obsessions/compulsions <input type="checkbox"/> oppositional defiance <input type="checkbox"/> orientation/memory problems <input type="checkbox"/> panic attacks <input type="checkbox"/> paranoia <input type="checkbox"/> poor concentration/attention <input type="checkbox"/> comprehension <input type="checkbox"/> conversation <input type="checkbox"/> mobility <input type="checkbox"/> pressured speech <input type="checkbox"/> severe mood swings <input type="checkbox"/> sleep disturbance <input type="checkbox"/> somatic complaints <input type="checkbox"/> agitation <input type="checkbox"/> irritability <input type="checkbox"/> disorganized speech <input type="checkbox"/> ADLs <input type="checkbox"/> Assertiveness <input type="checkbox"/> Sadness <input type="checkbox"/> Grief/loss <input type="checkbox"/> Job/School/Home work Performance <input type="checkbox"/> Loneliness <input type="checkbox"/> Shyness <input type="checkbox"/> Guilt <input type="checkbox"/> Self-esteem <input type="checkbox"/> Thoughts <input type="checkbox"/> Nightmares <input type="checkbox"/> Stress <input type="checkbox"/> Self-harm <input type="checkbox"/> Friends/Social/Relationships <input type="checkbox"/> Family <input type="checkbox"/> Parents <input type="checkbox"/> Past events <input type="checkbox"/> Divorce <input type="checkbox"/> Separation <input type="checkbox"/> Marriage <input type="checkbox"/> Premarital <input type="checkbox"/> Dating <input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> In-laws <input type="checkbox"/> Infertility <input type="checkbox"/> Parenting <input type="checkbox"/> Infidelity <input type="checkbox"/> Sexuality <input type="checkbox"/> Gender Identity <input type="checkbox"/> Sexual addiction <input type="checkbox"/> Eating disorder <input type="checkbox"/> Financial <input type="checkbox"/> Housing <input type="checkbox"/> Culture <input type="checkbox"/> Language <input type="checkbox"/> Personality <input type="checkbox"/> Community <input type="checkbox"/> Fears: _____ . <b>Circle items causing MOST difficulty.</b>					
When did you first experience symptoms related to this visit?					
Strengths:			Weaknesses:		
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Spiritual or religious beliefs:		Interests, hobbies, and activities:	
Who is important in your life?			
Education history:		Occupational history:	
Have you experienced <b>physical</b> violence? <input type="checkbox"/> No <input type="checkbox"/> Yes (event, when, response):			
Have you experienced <b>verbal</b> abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes:			
Have you ever seriously contemplated suicide? <input type="checkbox"/> No <input type="checkbox"/> Yes (when):		Suicide attempted? <input type="checkbox"/> No <input type="checkbox"/> Yes: #attempts, dates:	
Current suicidal ideation? <input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Daily; Imminent risk of harm/elopement potential: <input type="checkbox"/> No <input type="checkbox"/> Yes:			
Psychiatric hospitalization #, Dates, Diagnosis, Treatment:			
Legal history: <input type="checkbox"/> DHS Income Supports/ <input type="checkbox"/> Child Protection, <input type="checkbox"/> Youth Diversion, <input type="checkbox"/> Criminal Justice/ <input type="checkbox"/> Probation, <input type="checkbox"/> Substance Abuse Arrests and/or <input type="checkbox"/> Treatment, <input type="checkbox"/> Domestic Violence Intervention Victim Services/ <input type="checkbox"/> Offender Treatment, <input type="checkbox"/> Veteran's Services, <input type="checkbox"/> Corrections History/ <input type="checkbox"/> Parole/ <input type="checkbox"/> Community Corrections/ <input type="checkbox"/> Reentry, <input type="checkbox"/> Foster Care:			
<b>Family History</b>			
Members of Household: Name		Age	Gender (Biological, adopted, foster, step, etc.)? Special needs?
Do you have family members not currently living with you? <input type="checkbox"/> No <input type="checkbox"/> Yes; How often do you see them or contact them?			
Name	Age	Gender	Relation (Biological, adopted, foster, step, etc.)
Partner's occupation:		Length of relationship:	
Describe your partner's personality:			
How do you resolve conflicts or differences?			
<b>If previously married</b> , please complete the following:			
1 <sup>st</sup> marriage: Date married:		Date ended:	Ex-spouse's name:
Children: <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason for divorce:	
2 <sup>nd</sup> marriage: Date married:		Date ended:	Ex-spouse's name:
Children: <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason for divorce:	
<b>Father</b> <input type="checkbox"/> Living, Age:	Occupation:	Health:	
<input type="checkbox"/> Deceased, Cause:		Your age at the time of his death:	
Describe your father's personality:			
<b>Mother</b> <input type="checkbox"/> Living, Age:	Occupation:	Health:	
<input type="checkbox"/> 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:			
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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 <input type="checkbox"/> No <input type="checkbox"/> Yes:	
Family members with serious medical health conditions, i.e. epilepsy <input type="checkbox"/> No <input type="checkbox"/> Yes (who has what?):	
Family members with a mental health diagnosis? <input type="checkbox"/> No <input type="checkbox"/> Yes:	
<b>Developmental history</b> (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:	
<b>Substance Use</b>	
<b>Alcohol:</b> <input type="checkbox"/> Abstinent <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly x _____ # Years/Mos Quantity: _____ Age First Used: _____ Date Last Use:	
<b>Tobacco:</b> <input type="checkbox"/> Abstinent <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly x _____ # Years/Mos Quantity: _____ Age First Used: _____ Date Last Use:	
<b>Caffeine:</b> <input type="checkbox"/> Abstinent <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly x _____ # Years/Mos Quantity: _____ Age First Used: _____ Date Last Use:	
<b>History(underline)/Current(circle)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes: Marijuana/synthetic, Cocaine, LSD, Prescription/OTC Drugs, Crystal Meth, Heroin, Ecstasy, Other: _____ <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly x _____ # Years/Mos Quantity: _____ Age First Used: _____ Date Last Use:	
Have you been arrested for driving under the influence? <input type="checkbox"/> No <input type="checkbox"/> Yes Date(s):	
Has anyone said your use is a problem? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you had times you cannot remember, the day after you used drugs/alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes How often?	
Have you received substance abuse treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes, Dates, Where, Outcome:	
Have you tried to quit? <input type="checkbox"/> No <input type="checkbox"/> Yes, Outcome:	
Does your use cause harm to self or others? <input type="checkbox"/> No <input type="checkbox"/> Yes(who, how):	
Are you considering screening this as a goal? <input type="checkbox"/> No <input type="checkbox"/> Yes:	
Level of Care evaluation:	
Acute Intoxication and/or Withdrawal Potential <input type="checkbox"/> No <input type="checkbox"/> Yes:	
Biomedical Conditions and Complications <input type="checkbox"/> No <input type="checkbox"/> Yes:	
Emotional, Behavioral or Cognitive Conditions and Complications <input type="checkbox"/> No <input type="checkbox"/> Yes:	
Readiness to Change <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Precontemplation <input type="checkbox"/> Contemplation <input type="checkbox"/> Preparation <input type="checkbox"/> Action <input type="checkbox"/> Maintenance	
Relapse, Continued Use or Continued Problem Potential <input type="checkbox"/> No <input type="checkbox"/> Yes:	
Recover/Living Environment <input type="checkbox"/> No <input type="checkbox"/> Yes:	
<b>Sexual History</b>	
Parental attitudes learned about sex (values/instruction/discussion):	
Are you sexually active? <input type="checkbox"/> Yes (age you first become sexually active): <input type="checkbox"/> No Is your present sex life satisfactory? <input type="checkbox"/> Yes <input type="checkbox"/> No (problems: addictions, anxiety, guilt, low desire, high desire, lacks emotional intimacy, etc.): Would you like this to be one of our goals? <input type="checkbox"/> No <input type="checkbox"/> Yes(specify):	
Have you experienced sexual abuse?( <i>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.</i> ) <input type="checkbox"/> No <input type="checkbox"/> Yes (circumstances, people involved, response action):	
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