ONEHEARTTLC COUNSELING – ADULT BIOPSYCHOSOCIAL ASSESSMENT

DEMOGRAPHICS

Legal Name:		
Age:	Date of Birth:	Social Security #:
Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Native American ☐ Other:		
Current Address: Street: City/State: Zip:		Current Phone: Home: Cell:
Emergency Contact:		Phone:
☐ Guardian ☐ Representative payee ☐ Personal representative Name: ___________________________________ Phone: ______________________________		
Insurance Information: ☐ Medicaid ☐ Medicare ☐ Blue Cross/Blue Shield ☐ MiChild ☐ Value Options ☐ Cigna ☐ United Behavioral Healthcare ☐ Aetna ☐ Adult Benefit Waiver ☐ Medicaid Spend down ☐ Other ______________________________ ☐ No Insurance Benefits – current household income: ______________________________SUBSTANCE USE HISTORY:		

Consequences as a result of Drug/Alcohol Use (select all that apply)

☐ Hangovers	☐ Seizures	☐ Sleep Problems	☐ Drinking & Driving
☐ Overdoses	☐ Liver Disease	☐ Lost Job	☐ Stealing for drugs
☐ Binges	☐ GI Bleeding	☐ Left School	☐ Arrest
☐ Blackouts	☐ Increased tolerance (need more to get high)	☐ Relationship Losses	☐ Jail
☐ DTs/Shakes		☐ Traded sex for drugs	☐ Other:

Risk Taking/Impulsive Behaviors (current or past) – select all that apply

☐ Gambling	☐ Gang involvement	☐ Selling drugs	☐ Reckless driving
☐ Unprotected sex	☐ Shoplifting	☐ Carry/using weapons	☐ Other ____________

Client's thoughts about making changes to substance use:

☐ Not ready to quit	☐ Making plans to quit	☐ Quit and need help to prevent a relapse
☐ Thinking about quitting	☐ Already started making change	

History of Substance Abuse Treatment: ☐ No previous treatment

Name of Treatment Program	Type of Treatment	Date of Treatment	Status
	☐ Inpatient ☐ IOP ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:
	☐ Inpatient ☐ IOP ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:
	☐ Inpatient ☐ IOP ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:
	☐ Inpatient ☐ IOP ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:
	☐ Inpatient ☐ IOP ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:

Clinical Impression: (Staff use only):

Client Name: ____

PSYCHOLOGICAL/EMOTIONAL:

Check all current symptoms:

☐ Depressed mood	☐ No motivation	☐ Sleep problems	☐ Hallucinations
☐ Frequent crying spells	☐ No interest in activities	☐ Manic episode	☐ Paranoia
☐ No energy	☐ Changes in weight	☐ Panic attacks	☐ Thoughts of death
☐ Irritable often	☐ Feeling worthless	☐ Constant worry	☐ Obsessions
☐ Problems concentrating	☐ Hopelessness	☐ Anxiety	☐ Hyperactivity

History of Suicide Attempts ☐ No ☐ Yes When:__________________________ How: ___________________

History of Hurting Others ☐ No ☐ Yes When: _________________________ How: ___________________

Past/Current Mental Health Diagnosis: ____

Current Mental Health Medications: ____

Doctor prescribing medications? Name: __________________________________ Phone: ___________________

Address: ____

Past Mental Health Medications: ____

Family history of mental health disorders:

Family Member	Diagnosis

History of Mental Health Treatment: ☐ No previous treatment

Name of Treatment Program	Type of Treatment	Date of Treatment	Status
	☐ Hospital ☐ Partial Day ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:
	☐ Hospital ☐ Partial Day ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:
	☐ Hospital ☐ Partial Day ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:
	☐ Hospital ☐ Partial Day ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:
	☐ Hospital ☐ Partial Day ☐ Outpatient		☐ Completed ☐ Dropped Out ☐ Other:

Clinical Impression: (Staff use only):

Client Name: _____

MEDICAL:

Medical Condition(s):	Medication(s)	Dose

Allergic to any medications? ☐ No☐ Yes What medication(s)? _____

Primary Care Physician's Name: ☐ No primary care physician	Address:	Phone:
Detoxification History: Substance(s): _____ ☐ Never detoxed Symptoms: ☐ DTs/Shakes ☐ Vomiting ☐ Diarrhea ☐ Seizures ☐ Achy ☐ Sleeplessness ☐ No appetite ☐ Anxiety ☐ Hallucinations ☐ Other: _____		
Current Sleep: ☐ No sleep problems ☐ Can't fall asleep ☐ Waking often in the night ☐ Sleep more than 9 hours per night ☐ Sleep less than 6 hours per night		
Current Exercise: ☐ None ☐ Exercise 1-3x/month ☐ Exercise 1-3x/week ☐ Exercise daily		
Current Diet: ☐ Healthy eating ☐ Overeating ☐ Eating mostly junk food ☐ Bulimia (eating too much and vomiting) ☐ Anorexia (not eating enough)		
Current appetite: ☐ Good ☐ Fair ☐ Poor		

Clinical Impressions: (Staff use only):

FAMILY OF ORIGIN: (What happened while growing up – check all that apply)

Who raised client? ☐ Mother ☐ Father ☐ Grandparent ☐ Other: _____
Substance use in the family? ☐ No ☐ Yes Who? _____
Client was disciplined by: ☐ Not disciplined ☐ Spanked/hit ☐ Yelled at ☐ Time out/grounding
Verbal Abuse? ☐ No ☐ Yes Age of abuse _____By Whom? _____
Physical Abuse? ☐ No ☐ Yes Age of abuse _____By Whom? _____
Neglect? ☐ No ☐ Yes Age of abuse _____By Whom? _____
Impression of upbringing: ☐ Healthy ☐ Fair ☐ Dysfunctional

Clinical Impressions: (Staff use only):

ETHINIC/CULTURAL/SPIRITUAL BACKGROUND:

What cultural group do you identify with the most (check all that apply):

☐ Caucasian (White)	☐ African American (Black)	☐ Latino
☐ Asian	☐ Hispanic	☐ Native American
☐ Other: _____		

What religious group do you identify with the most (check all that apply):

☐ None	☐ Baptist	☐ Lutheran	☐ Protestant	☐ Jewish
☐ Catholic	☐ Muslim	☐ Non-denominational	☐ Jehovah Witness	☐ Other: _____

What are your spiritual beliefs?

☐ Believe in Higher Power	☐ Uses prayer	☐ Seeking connection with others
☐ Seeking harmony	☐ Believe in Karma	☐ Want to strengthen spirituality

Clinical Impressions: (Staff use only):

Client Name: _____

SEXUALITY:

Check all that apply:

Sexual Orientation: ☐ Heterosexual (like opposite sex) ☐ Homosexual/Gay/Lesbian
☐ Bisexual (like both sexes) ☐ Transgender
☐ Comfortable with sexual orientation ☐ Concerns with sexual orientation

Sexual abuse: ☐ Have been sexually abused Age of abuse:_____ By whom: _____
☐ Have sexually abused others
☐ No history of sexual abuse
☐ Sexual abuse history is a current area of concern

Clinical Impressions: (Staff use only):

CURRENT FAMILY RELATIONSHIPS:

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Living with partner ☐ In relationship

Children: ☐ None

Name	Age	Gender	Client has custody?	Child lives with?	Additional information
		☐ M ☐ F	☐ Yes ☐ No		
		☐ M ☐ F	☐ Yes ☐ No		
		☐ M ☐ F	☐ Yes ☐ No		
		☐ M ☐ F	☐ Yes ☐ No		

Has client ever had involvement with Child Protective Services? ☐ No ☐ Yes Year: _____

Check all that apply:

	Deceased	Regular contact	Infrequent/ No contact	Supports recovery	Does not understand recovery	Used substances with	Conflict in relationship
Spouse/Partner							
Mother							

Father							
Sibling: _____							
Sibling: _____							
Sibling: _____							
Child: _____							
Child:_____							

Identify family that would be willing to participate in treatment to assist client in recovery: _____

Clinical Impression: (Staff use only):

Client Name: _____

CURRENT SOCIAL SUPPORTS:

Check all that apply:

□ No current social support	□ Isolating	□ Have a current sponsor
□ Friends that use substances	□ Anxiety makes it hard to meet people	□ Friends that support recovery

AA/NA Meetings (check all that apply):

□ Never attended any meetings	□ Don't like meetings	□ Attend meetings 1-3x/month
□ Attended meeting in the past	□ Find meetings helpful	□ Attend meetings 1-3x/week
□ Currently attending meetings	□ Need to go to meetings again	□ Attend meetings daily

Clinical Impression: (Staff use only):

CURRENT LEISURE/RECREATION/TIME MANAGEMENT:

Check all that apply: □ Do not participate in any activities

Activity	Past activity	Present activity	Substance use involved with this activity
Time with friends			
Time with family			
Classes/School			
Work			
Hobby: _____			
Watch television/Play video games			
Clubs/Bars			
Casinos			
Participate in sports/exercise			
Other: _____			

Clinical Impression: (Staff use only):

EDUCATIONAL:

Check all that apply:

Education: ☐ High School Graduate or GED ☐ Less than 12 years of school: Last grade completed: _____ ☐ College: # of years _____ ☐ Vocational Schooling: # of years _____
Current Schooling: ☐ No ☐ Yes
Do you need help with reading and/or writing? ☐ No ☐ Yes
Any learning disabilities or other educational or learning problems? ☐ No ☐ Yes: _____
How do you learn the best? ☐ Reading ☐ Writing ☐ Listening to information ☐ Practicing

Clinical Impression: (Staff use only):

Client Name: _____

EMPLOYMENT/VOCATIONAL:

☐ EMPLOYED ☐ Full-time ☐ Part-time ☐ Contractual/Side Jobs Employer: _____ Length of Employment: _____ Job Description: _____ Check all that apply: ☐ Satisfied ☐ Not satisfied ☐ Conflict with supervisor ☐ Conflict with coworkers ☐ I have used substances at work ☐ Others use substances at work ☐ Employment will help with recovery ☐ Employment could hurt recovery Explanation: _____
☐ UNEMPLOYED Last employer: _____ Reason for leaving: _____ ☐ Currently looking for work ☐ Disabled ☐ Need job skills training ☐ Currently in school ☐ Never been employed ☐ Homemaker ☐ Unstable work history ☐ History of Military service ☐ Not looking for work due to: _____

Clinical Impression: (Staff use only):

LEGAL:

Current Legal Status: ☐ None ☐ Probation ☐ Parole ☐ Awaiting Sentencing ☐ Awaiting Trial

History of Legal Charges:

Charge (most recent first)	Year Arrested for Charge	Outcome

Clinical Impression: (Staff use only):

FINANCIAL STATUS:

Check all that apply:

Finances are: ☐ Stable ☐ Struggling to pay bills ☐ Need assistance with basic needs

Need help with: ☐ Nothing ☐ Rent/Mortgage ☐ Food ☐ Utilities (electric, gas, water)
☐ Healthcare ☐ Transportation ☐ Other: _____

Money management: ☐ Able to budget ☐ Gambling problems ☐ Compulsive spending ☐ Hoarding money

Clinical Impression: (Staff use only):

Client Name: _____

FUNCTIONAL ASSESSMENT:

Client able to care for self? ☐ Yes ☐ No – Explain:

Living Situation: ☐ Housing adequate ☐ Housing overcrowded ☐ Housing dangerous
☐ Doubled up – living in someone else's house ☐ Transitional or ¾ housing
☐ Homeless ☐ Temporary Shelter ☐ At risk of homelessness

Assistive/Adaptive Needs: ☐ Glasses/Contacts ☐ Braille ☐ Cane
☐ None ☐ Hearing Aids ☐ Reads lips ☐ Needs sign language
☐ Walker ☐ Crutches ☐ Wheelchair
☐ Translated verbal information – Language: _____
☐ Translated written information – Language: _____

SNAP *(Strengths, Needs, Abilities and Preferences)*

Strengths: ☐ Family support ☐ Desire for help ☐ Social support ☐ Financial stability ☐ Spiritual
☐ Resilient ☐ Stable relationship ☐ Stable housing ☐ Other: _____

Needs: ☐ Coping skills ☐ Relapse prevention skills ☐ Support for recovery ☐ Medications
☐ Transportation ☐ Financial help ☐ Other: _____

Abilities: ☐ Insightful ☐ Good communication skills ☐ Good writing skills
☐ Other: _____

Preferences: ☐ Appointment times – Needs: _____ ☐ Therapist in Recovery
☐ Male Therapist ☐ Female Therapist ☐ Group therapy ☐ Individual therapy

**********************************STAFF USE ONLY*************************************

INTERPRETIVE SUMMARY for MENTAL HEALTH

Therapist Signature and Credentials — Date

Supervisor's Signature — Date