Integrated Biopsychosocial Assessment Form

General Information

Today's Date: _____

Full Name: _____

Name You Prefer to Be Called: _____

I am seeking help for: (Check all that apply.)

o 1- Depression
o 2- Anxiety
o 3- Relationship Problems
o 4- Homelessness
o 5- Job Problems
o 6- School Problems
o 7- Drug Problem
o 8- Alcohol Problem
o 9- Legal Problems
o 10- Domestic Violence/Abuse
o 11- Not Sure
o 12- Other: _____ _____

I was referred here by:

o 1- Physician or Psychiatrist
o 2- Friend or Relative
o 3- Clergy
o 4- Employer or School
o 5- DCF (Dept. of Children and Families)
o 6- Judge/Court/Legal
o 7- Myself
o 8- Probation/Parole Officer
o 9- Other: _____

The language spoken most often in my home is:

o 1- English
o 2- Spanish
o 3- Other:_____

My income comes from: (Check all that apply.)

o 1- Family or Relatives
o 2- SSI/SSDI, all or part
o 3- Food stamps
o 4- Welfare (TANF/W.A.G.E.S.)
o 5- Part-time job.
o 6- Full-time job.
o 7- Other source:
o 8- I have no income.

In the past year my income has:

o 1- Not changed
o 2- Increased
o 3- Decreased

If changed, it was:

o 4- Expected
o 5- Not expected

Due to my problems, during the last <u>month</u> at work or school I have missed:

o 1- 0 days
o 2- 1-3 days
o 3- 4-6 days
o 4- 7-9 days
o 5- 10 or more days
o 6- Not working or in school

My concerns or problems I have at work or school are:

_____
_____
_____
_____
_____
_____
_____

Staff Use Only

Relationships and Family

Children and other people living or staying with me:

Name	Relationship	Part-time	Full-time
		o	o
		o	o
		o	o
		o	o
		o	o

I am currently married or in a significant relationship. o 1- Yes o 2- No

If Yes, this relationship is: o 3- Good o 4- Fair o 5- Poor
Why? _____

History of marriages and significant relationships:

Name	Relationship	Approximate Dates

My current relationship with my family is:
o 1- Good o 2- Fair o 3- Poor o 4- Not applicable
Why? _____

My current relationship with my friends is:
o 1- Good o 2- Fair o 3- Poor
Why? _____

I receive some emotional support from my family and/or friends:
o 1- Yes (Is it enough? o 2- Yes o 3- No)
o 4- No o 5- Other source(s)

Overall, my childhood was:
o 1- Good o 2- Fair o 3- Poor
Why? _____

My relationship with my mother growing up was:
o 1- Good o 2- Fair o 3- Poor o 4- Not applicable
Why? _____

My relationship with my father growing up was:
o 1- Good o 2- Fair o 3- Poor o 4- Not applicable
Why? _____

My relationship with my friends as a child was:
o 1- Good o 2- Fair o 3- Poor
Why? _____

My relationship with other family members growing up was:
o 1- Good o 2- Fair o 3- Poor o 4- Not applicable
Why? _____

A significant friend or relative of mine has died in the last year
o 1- Yes o 2- No
If Yes, who? Cause of death

Staff Use Only

Children 18 and Younger *(Please include stepchildren and adopted children as well as biological children.)*

For each child:	**Name of child:** _____	**Name of child:** _____	**Name of child:** _____	**Name of child:** _____	**Name of child:** _____
Age	_____	_____	_____	_____	_____
Sex Male	o 1	o 1	o 1	o 1	o 1
Female	o 2	o 2	o 2	o 2	o 2
My status as a parent is:					
Biological parent	o 1	o 1	o 1	o 1	o 1
Step-parent	o 2	o 2	o 2	o 2	o 2
Foster parent	o 3	o 3	o 3	o 3	o 3
Adoptive parent	o 4	o 4	o 4	o 4	o 4
Other	o 5	o 5	o 5	o 5	o 5
Custody status (past 30 days)					
Full custody	o 1	o 1	o 1	o 1	o 1
Not in my custody temporarily	o 2	o 2	o 2	o 2	o 2
Not in my custody permanently	o 3	o 3	o 3	o 3	o 3
Joint custody	o 4	o 4	o 4	o 4	o 4
Other	o 5	o 5	o 5	o 5	o 5
Living arrangements (past 30 days)					
In my household	o 1	o 1	o 1	o 1	o 1
With other parent	o 3	o 3	o 3	o 3	o 3
In foster care	o 4	o 4	o 4	o 4	o 4
Other	o 5	o 5	o 5	o 5	o 5
Does this child have any learning or behavioral problems?					
No	o 1	o 1	o 1	o 1	o 1
Yes, not getting help	o 2	o 2	o 2	o 2	o 2
Yes, getting help	o 3	o 3	o 3	o 3	o 3
If Yes, please describe					
Other Parent of Child (Check all that apply.)					
Name:	_____	_____	_____	_____	_____
Lives with me & child	o 1	o 1	o 1	o 1	o 1
Has custody of child	o 2	o 2	o 2	o 2	o 2
Shares custody w/me	o 3	o 3	o 3	o 3	o 3
Has visitation rights	o 4	o 4	o 4	o 4	o 4
Contributes to support	o 5	o 5	o 5	o 5	o 5
Is involved with child	o 6	o 6	o 6	o 6	o 6

Please note any childcare arrangements, other caregivers, custody issues, etc. that you think are important.

Staff Use Only

Relationships and Family (cont.)

Significant Other People Who Don't Live with You
(parents, sisters, brothers, children over 18, grandparents, other relatives, etc.)

Name	Relationship	Age	√ if Deceased	Cause of Death	Amount of Contact	Health
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor
						o 1- Good o 2- Fair o 3- Poor

Staff Use Only

Religion/Culture

What holidays do you observe?

Do you consider yourself religious? o 1- Yes o 2- No

Do you attend religious services regularly? o 1- Yes o 2- No

What are the religious, spiritual, cultural, or ethnic considerations that we should be aware of as we meet with you?

Staff Use Only

Education

Are you currently enrolled in school/college/training? o 1- Yes o 2- No

If Yes, o 1- Full-time o 2- Part-time

If Yes, where?

The highest grade I completed in school was: _____

For *me* school was: o 1- Good o 2- Fair o 3- Poor

List degrees, licenses, special training, etc.:

_____
_____
_____
_____
_____
_____

Staff Use Only

Employment/Military

Current Employment:

o 1- Full-time
o 2- Part-time
o 3-Volunteer work
o 4- Unemployed

What kind of work do you do?

Relationship with co-workers	**Relationship with supervisor**
o 1- Good o 2- Fair o 3- Poor	o 1- Good o 2- Fair o 3- Poor

How long have you been there?

How many days did you work in the last month?

What was your favorite job?

Military Service: o 1- Yes o 2- No **If Yes, dates: _____**

Were you ever in combat? o 3- Yes o 4- No

Comments:

Staff Use Only

Legal

Were you forced into seeking treatment? o 1- Yes o 2- No **If Yes, give details:**

Have you ever been arrested? o 1- Yes o 2- No **If Yes, how many times were you arrested?** _____

Are you waiting to go to trial/hearing o 1- Yes o 2- No **If Yes, date of trial/hearing** _____

Current Probation o 1- Yes o 2- No	**Current Parole** o 1- Yes o 2- No	**Current Drug Court** o 1- Yes o 2- No	**Current Domestic Violence Court** o 1- Yes o 2- No

Please list all arrests beginning with the most recent (include DUI's and DWI's).

Date							
Charge							
Results & Penalties (Check all that apply.)							
Not guilty	o 1	o 1	o 1	o 1	o 1	o 1	o 1
Adjudication witheld	o 2	o 2	o 2	o 2	o 2	o 2	o 2
Probation	o 3	o 3	o 3	o 3	o 3	o 3	o 3
Fine	o 4	o 4	o 4	o 4	o 4	o 4	o 4
Time served	o 5	o 5	o 5	o 5	o 5	o 5	o 5
Community service	o 6	o 6	o 6	o 6	o 6	o 6	o 6
Jail time Place Dates	o 7 _____ _____	o 7 _____ _____	o 7 _____ _____	o 7 _____ _____	o 7 _____ _____	o 7 _____ _____	o 7 _____ _____
Prison time Place Dates	o 8 _____ _____	o 8 _____ _____	o 8 _____ _____	o 8 _____ _____	o 8 _____ _____	o 8 _____ _____	o 8 _____ _____
Other (describe)	o 9	o 9	o 9	o 9	o 9	o 9	o 9

Staff Use Only

Has the client ever been "Incompetent to Proceed" or "Not Guilty by Reason of Insanity"? o 1- Yes o 2- No

Alcohol and Other Drugs

Do members of your family use alcohol or other drugs?

o 1- Yes o 2- No o 3- Not applicable **If Yes, who?**

Do members of your family have a history of alcoholism or problems with drinking or drugs? o 1- Yes o 2- No o 3- Not applicable

If Yes, who?

At any time in the last 30 days, have you felt that you should reduce or stop:

Smoking cigarettes? o 1- Yes o 2- No o 3- Do not use

Alcohol use? o 4- Yes o 5- No o 6- Do not use

Drug use? o 7- Yes o 8- No o 9- Do not use

Has drinking or taking drugs caused you any problems with school, work, friends, family, spouse, police, or your health?

Currently o 1- Yes o 2- No

Within the last year o 1- Yes o 2- No

Please explain problems:

Was drinking or using drugs a problem for you at one point in your life but not a problem now? o 1- Yes o 2- No o 3- Never used/drank

Has anyone else expressed concern about your drinking/drug use?

o 1- Yes o 2- No o 3- Do not use drugs or drink

If yes, who? _____

Does your personality change under the influence?

o 1- Yes o 2- No o 3- Do not drink or use drugs

If yes, describe briefly:

Has your use of alcohol or other drugs made any mental health problems you have worse? o 1- Yes o 2- No o 3- Do not use drugs or drink

If yes, please explain:

Have you ever blacked out when drinking? o 1- Yes o 2- No

Have you ever attended AA? o 1- Yes o 2- No **NA?** o 3- Yes o 4- No

If yes, about how long did you attend? _____

What is the longest you were ever clean & sober? _____

Comments you want to make:

Staff Use Only

Alcohol and Other Drugs (cont.)

Type of Drug	√ Check if used: Ever	Last 6 Months	Last 48 Hours	Age of First Use	During the last 6 months, what is the most you have used in one day?
Alcohol: beer, wine, wine coolers, liquor, etc.	o	o	o		
Amphetamines: "speed," "uppers", "crystal," methamphetamine, "crank," etc. o 01- Pills o 02- Smoke	o	o	o		
Cannabis: marijuana, "pot," hashish	o	o	o		
Cocaine and Crack Cocaine: "blow," "rock," "coke," freebase, etc. o 01- Powdered cocaine o 02- Crack, freebase	o	o	o		
Hallucinogens: LSD, "ecstasy," MDA, DMT, mescaline, psilocybin mushrooms, etc.	o	o	o		
Inhalants: glue, gasoline, paint thinner, spray can propellant, etc.	o	o	o		
Opioids: heroin, Demerol, codeine, morphine, fentanyl, "China white," methadone, etc. o 01- Injection o 02- Other intake	o	o	o		
Phencyclidine & Similar: PCP, ketamine, "K," etc.	o	o	o		
Sedatives, Hypnotics & Anxiolytics: barbiturates, "downers," benzodiazepines, Xanax, Valium, "roofies," etc.	o	o	o		
Other: Darvocet, steroids, GHB, amyl nitrite, "poppers," "rush," etc.	o	o	o		
Nicotine: cigarettes, chewing tobacco, cigars, dip, etc.	o	o	o		

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Medications

Current Medications (including medical):

Medication Name	Date Prescribed	Dosage/Frequency	Doctor	Side Effects	Taken as Prescribed?
					o 1- Yes o 2- No
					o 1- Yes o 2- No
					o 1- Yes o 2- No
					o 1- Yes o 2- No
					o 1- Yes o 2- No
					o 1- Yes o 2- No

Previous Medications (last 2 years, including medical):

Medication Name	Dates	Dosage/Frequency/ Response	Doctor	Side Effects	Taken as Prescribed?
					o 1- Yes o 2- No
					o 1- Yes o 2- No
					o 1- Yes o 2- No
					o 1- Yes o 2- No
					o 1- Yes o 2- No
					o 1- Yes o 2- No

Staff Use Only

Medical

Please describe any significant disease, surgeries, or injuries from your past or present:

_____

_____

Do you have any known allergies, including medication allergies?
o 1- Yes o 2- No **If yes, describe:**

My present physician(s):
1._____ **Last contact** _____
2._____ **Last contact** _____

My last physical examination was on (date) _____
by Dr. _____

I am: o 1- **Not on a special diet** o 2- **On a special diet involving**

Do you want information on family planning?
o 1- Yes o 2- No

Have you or your partner ever had a problem birth, miscarriage, or abortion? o 1- Yes o 2- No

WOMEN ONLY: Are you pregnant? o 1- Yes o 2- No
If Yes, are you receiving medical care for pregnancy? o 3- Yes o 4- No
If Yes, where? _____

Staff Use Only

Mental Health

Have any members of your family had: (Check all that apply.)

o 1- Depression?
o 2- Anxiety?
o 3- Mental illness?
o 4- Job problems?
o 6- Drug/alcoholism problems?
o 7- Legal problems?
o 8- Other?: _____
_____

Have you ever seen a counselor or psychiatrist about a problem?
o 1- Yes o 2- No

If Yes, did he or she recommend services for you? o 1- Yes o 2- No

If Yes, did you complete this treatment? o 1- Yes o 2- No

Have you recently received: (Check all that apply.)

o 1- Counseling or psychiatric care?
o 2- Inpatient psychiatric treatment?
o 3-. Medications for depression/anxiety from my primary care doctor?
o 4- Other services?

During the last 6 months have you thought of killing yourself?
o 1- Yes o 2- No

How many times have you attempted suicide? _____

During the last month how often have you felt well enough to do what you usually do during the day?

o 1- Never
o 2- Seldom
o 3- Often
o 4- Very frequently

During the last month how often have you been getting out of the house to do the things you enjoy?

o 1- Never
o 2- Seldom
o 3- Often
o 4- Very frequently

Are you concerned about any sexual issues, past or present?
o 1- Yes o 2- No If Yes, please explain:
_____
_____

Have there been times in the past when your appetite changed a lot?
o 1- Yes o 2- No

During the last 6 months you	**Your appetite the last month has been:**
o 1- Maintained the same weight.	o 1- Normal
o 2- Gained ____ pounds.	o 2- Eating more than normal
o 3- Lost pounds	o 3- Poor

Have you had sleep problems in the past? o 1- Yes o 2- No

Have there been times when you didn't need much sleep?
o 1- Yes o 2- No-

Your usual sleep pattern is: (Check all that apply.)

o 1- Normal sleep
o 2- Problems falling asleep
o 3- Problems staying asleep
o 4- Nightmares
o 5- Irregular sleep
o 6- Sleep too much

Staff Use Only

Violence and Trauma

Were you ever punished resulting in bruises, cuts, burns, or other injuries? o 1- Yes o 2- No **Age: ____**
If Yes, please describe:

Did you ever see your parents physically fighting or causing injury to your brothers or sisters? o 1- Yes o 2- No **Age: ____**
If Yes, please describe:

Did your spouse, partner, boyfriend, or girlfriend ever hit, slap, or punch you during an argument? o 1- Yes o 2- No **Age: ____**
If Yes, please describe:

Was anyone arrested? o 1- Yes o 2- No
Did you receive any kind of counseling/treatment? o 1- Yes o 2- No
If Yes, please describe:

Were you ever beaten up, hit, slapped, or assaulted by anyone not mentioned in the question above? o 1- Yes o 2- No **Age:__**
If Yes, please describe:

Did you ever witness a violent death or extreme violence against someone else? o 1- Yes o 2- No **Age: ____**
If Yes, please describe:

Did your parents or your partner ever have a pattern of making threats, putting you down, calling you names, or humiliating you?
o 1- Yes o 2- No **Age: ____** **If Yes, please describe:**

Did you ever witness or were you involved in a severe accident (wreck, drowning, fire, etc.)? o 1- Yes o 2- No **Age: _____**
If Yes, please describe:

Did you ever witness a violent death or extreme violence against someone else? o 1- Yes o 2- No **Age: ____**
If Yes, please describe:

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Were you ever a victim of a violent or potentially violent theft (armed robbery, mugging, etc.)? o 1- Yes o 2- No **Age: _____**

If Yes, please describe:

Were you ever raped? o 1- Yes o 2- No **Age:**

When you were a child, were you ever touched/fondled in a sexual way by someone older than you or made to touch/fondle their body in a sexual way? o 1- Yes o 2- No **Age:**

If Yes, did this happen once or more than once?

o 1- Once o 2- More than once

Comments you want to make:

After you became an adult, did someone touch/fondle your body in a sexual way or make you touch/fondle their body in a sexual way when you didn't want them to. o 1- Yes o 2- No

If Yes, did this happen once or more than once?

o 1- Once o 2- More than once

Comments you want to make:

Were you ever forced to have sex by your spouse/significant other?

o 1- Yes o 2- No

Comments you want to make:

Has anyone stalked you, in other words, followed you or kept track of your activities, causing you to feel intimidated or concerned for your safety? o 1- Yes o 2- No

If Yes, please describe:

If you answered yes to any of the above questions about violence and sexual trauma, do you *currently* experience any of the following?

Flashbacks	o 1- Yes o 2- No	Numbness	o 1- Yes o 2- No
Nightmares	o 1- Yes o 2- No	Other (write below)	o 1- Yes o 2- No
Insomnia	o 1- Yes o 2- No	_____	
Fearfulness	o 1- Yes o 2- No	_____	

Staff Use Only

Strengths

What are some things that will help you in treatment? Check all that apply and list others you think will help.

- o 1- Support from family (parents, children, others)
- o 2- Support from spouse or significant other
- o 3- Connection to self-help group (AA, NA, etc.)
- o 4- A positive and supportive sponsor
- o 5- Connection to a church group or minister
- o 6- Counselor or case manager who helped you get into treatment
- o 7- Judge or probation officer who helped you get into treatment
- o 8- Employer who helped you get into treatment
- o 9- Financial assistance or benefits
- o 10- Permanent residence
- o 11- Connection to a mental health facility and/or psychiatric care; provisions for obtaining medications
- o 12- Supportive friends
- o 13- Others:

_____

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Abilities

What are some of your personal qualities, skills, or talents that will help you in treatment? Check all that apply and list others you think will help.

- o 1- I am very motivated for treatment.
- o 2- I am able to make an appropriate transition to living in a recovering community.
- o 3- I have good interpersonal skills.
- o 4- I have good emotion-management skills.
- o 5- In the past I have demonstrated openness and honesty with regard to my recovery.
- o 6- I have been able to let go of the denial that I once had about my substance use.
- o 7- I have been able to let go of the denial that I once had about my mental disorders
- o 8- I have some insight into my substance use and mental disorders.
- o 9- I have good self-esteem.
- o 10- I have some positive plans and goals for my future.
- o 11- I am willing to do whatever it takes to be in recovery.
- o 12- I have a good relationship with a Higher Power.
- o 13- In spite of past hardships, there are still areas of my life in which I take pleasure.
- o 14- I am a caring person, capable of offering support to others in recovery.
- o 15- Others:

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Needs

What do you want to learn in treatment? Check all that apply and list other things you can think of that are not shown.

- o 1- Education about substance abuse
- o 2- Education about mental disorders
- o 3- An explanation of my diagnosis
- o 4- Improvement in my communications skills
- o 5- Improvement in my interpersonal skills/relationships
- o 6- Contact with supportive others
- o 7- Emotion-management skills
- o 8- Anger-management skills
- o 9- Education about improving my health
- o 10- Relapse-prevention education
- o 11- Others:

_____
_____
_____
_____
_____
_____

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Expectations

What do you hope to get out of treatment? Check all that apply and list other things you can think of that are not shown.

- o 1- I will learn the skills to stay clean and sober.
- o 2- I will learn the skills to stay mentally stable.
- o 3- I will have a better understanding of my diagnosis.
- o 4- I will be able to communicate more effectively.
- o 5- My interpersonal skills/relationships will improve.
- o 6- I will develop a system of support in recovery.
- o 7- I will be able to better manage my emotions.
- o 8- I will be able to better manage my anger.
- o 9- My health will improve.
- o 10- I will have a better understanding of relapse prevention.
- o 11- Others:

_____
_____
_____
_____
_____

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Goals

List some goals that you hope to achieve in the next few years.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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Preferences

What will you need to do to achieve your goals? What can we do to help you? What steps can be taken to reach your goals?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Staff Use Only

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Presenting Problem/Precipitating Factors

Significant History/Functional Status/Physical Condition

Mental Status	**Motor Activity, Behavior, Appearance, Mood, Affect, Sleep, Appetite**	
	Orientation, Memory, Cognitive, Insight/Judgment, Hallucinations, Delusions, Thought Processes	

Suicidal Ideations	**Homicidal Ideations**	**Implicit Contract**
O 1- Denies O 2- Voices	O 1- Denies O 2- Voices	
Intent/Plan	**Intent/Plan**	
O 1- Denies O 2- Voices	O 1- Denies O 2- Voices	

Diagnostic Impression	**Axis I**	**Axis III**
	Axis I	**Axis IV Psychological Stressors**
	Axis II	**Axis V: Current GAF Highest GAF in Past Year**

Prognosis O 1- Good O 2- Fair O 3- Guarded O 4- Poor	**Estimated Length of Stay**

Homework