Cone Health Behavioral Health

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BIOPSYCHOSOCIAL ASSESSMENT

Name: ___________________________________ Age: _________ Date: __________________________
Referred by: ______________________________ Form completed by Patient Staff Family(specify)
Primary Care Physician: ____
Physician's from whom you have received care during the last year (please put name of each physician and type and last date seen?)
____
____

PRESENTING PROBLEM

Chief complain (what brings you here today?):
____
____
What are the main stressors in your life right now?
____
____
Please circle all that apply to you (choose severity that applies: (1) mild, (2) moderate, or (3) severe)

Depression	1 2 3	Confusion	1 2 3	Panic Attacks	1 2 3
Anxiety	1 2 3	Memory Problems	1 2 3	Obsessive Thoughts	1 2 3
Moods Swings	1 2 3	Loss of in Interest	1 2 3	Ritualistic Behaviors	1 2 3
Appetite Change	1 2 3	Irritability	1 2 3	Checking	1 2 3
Sleep Changes	1 2 3	Excessive Worrying	1 2 3	Counting	1 2 3
Hallucinations	1 2 3	Suicidal thoughts	1 2 3	Change in Sexual Interest	1 2 3
Work Problems	1 2 3	Marital Stress	1 2 3	Poor Concentration	1 2 3
Racing Thoughts	1 2 3	Low Energy	1 2 3	Hyperactivity	1 2 3

Describe a brief history of your present symptoms:
____
____
How long have you had these symptoms?
____
____
What effect have they had on your life?
____
____

List Daily medications & Dosages (include over-the-counter drugs):

CURRENT MEDICATIONS	DOSAGE	PRESCRIBED BY	LAST DOSE	TAKING AS PRESCRIBED?

MEDICAL HISTORY

Previous Surgeries/Major Illnesses/Medical Diagnoses (include reason and year)

____

____

Please note if you have any other significant illness, condition or injury that you think may be important for us to know.

____

____

List any Medication or Food Allergies: ____

FOR CHILDREN/ADOLESCENTS: Pregnancy full term? Yes No How long? ________________________

Complications? No Yes(if yes what?)____

Milestones on time Yes No ____

Up-to-date on childhood inoculations? Yes No

Significant occurrences in child/adolescent's life ____

FAMILY HISTORY: Heart Attack Angina Colitis Sickle Cell Disease/Trait Emphysema Hepatitis/TB Neurological Problems/Seizures HIV Risk Factors High Blood Pressure Cancer Asthma Alcoholism/Drug Programs Emotional/Mental Illness other (please describe):

____

PAIN: No Problem Chronic Occasional, when: ____

Relief Measures: ____

PLEASE ANSWER ANY OF THE FOLLOWING THAT APPLIES TO YOU:

Do you use any herbal remedies? No Yes, Please list: ____

Are there guns in your home? No Yes

Have you: binged on food gone without eating vomited on purpose used laxatives to purge

MENTAL HEALTH HISTORY
Have you ever been treated for a mental health problem?   No   Yes, describe:
____
____
Where ________________________ By whom? ____
Are you currently seeing a therapist or counselor?   No   Yes, whom? ____________________________
Have you ever had a mental health hospitalization?   No   Yes, when? ____________________________
Where? ______________________ Why? _________________________ How many times? ____________
Have you every been treated with medication for a mental health problem?   No   Yes, please list as completely as possible (name of medication, reason prescribed, and response):
____
____
____

FAMILY MENTAL HEALTH HISTORY
Is there any history of mental health problems or substance abuse in your family?   No   Yes, please explain (include information on parents, siblings, aunts/uncles, grandparents, cousins, etc.):
____
____
Has anyone in your family been hospitalized for mental health problems?   No   Yes, please explain (including who, where, and for what length of time):
____
____

MARITAL STATUS
Are you presently: Single   Married   Divorced   Separated   Widowed
How many times have you been married? _____ Dates of previous marriages: ______________________
Do you have any concerns regarding marriage?   No   Yes, please explain:
____
____
Do you have any children?   No   Yes, how many? _____ Please list their sex and ages:
____

SOCIAL AND FAMILY HISTORY
Who lives in your current household?
____
Describe the household where you grew up:
____
Do you have siblings?   No   Yes, please list names, sex and ages:
____
Are your parents still living?   No   Yes If no, what was the cause of death?
____
Father's age_____   His health: ____
Mother's age ________   Her health: ____
Are your parents separated/divorced?   No   Yes, approximately when? __________________________
Have you been exposed to any form of abuse?   No   Yes: Physical   Sexual   Verbal   Emotional

Did the abuse happen recently, or in the past? _____________________ Were you the victim or offender, please explain: ____
Do you have any legal problems/ involvements? No Yes, please explain:
____
____

EDUCATIONAL BACKGROUND
How far did you go in school? ____
Any learning or behavioral issues in school? No Yes, explain:
____

WORK HISTORY
Do you work No Yes, what is your occupation? ____
Name of employer? ______________________________ Length of employment? _________________
Do you like your job? Why/why not? ____

SUBSTANCE USE (Fill out only if applicable)
Do you use caffeine? No Yes, what type? _______________________ How often? ______________
Do you use tobacco? No Yes, amount per day________ How many years at this frequency? _______
Do you use alcohol? No Yes, what type? _______________ Frequency? ________________________
When was your last drink? ______________ How much? ______________________________________
Have you ever experienced any form of withdrawal symptoms, i.e. Hallucinations, tremors, Excessive Sweating, or Nausea or Vomiting? No Yes, please explain: ___________________________________
Have you ever experienced blackouts? No Yes, how frequently: ______________________________
Have you ever had a DWI? No Yes, when? ____
Do you have any legal charges pending involving substance abuse? No Yes, please explain:
____
Have you ever used illicit drugs or taken more medication than prescribed? No Yes, what type:
____
Frequency: _____________________________ Date of last usage: ______________________________
How much? ____
Have you ever experienced withdrawal symptoms as listed above? No Yes, please explain:
____
If you are not using presently, have you ever used in the past? No Yes, what types of alcohol or other substances have you used? ____________________ Frequency? ___________ Last used? ______
Have you ever received treatment for alcohol or substance abuse problems? No Yes, was it: Inpatient or Outpatient What were the dates of treatment and where?
____
Have you ever been involved in any recovery or support programs? No Yes, where?
____
Please explain why or why not: ____
Are you aware of your triggers o drink or use? No Yes, please explain: ________________________