

Patient name \_\_\_\_\_ Date \_\_\_\_\_

## BIOPSYCHOSOCIAL HISTORY

Presenting problems

Duration (months)

Additional information:

\_\_\_\_\_

\_\_\_\_\_

### CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

**0-NONE** = This symptom not present at this time • **1-MILD** = Impacts quality of life, but no significant impairment of day-to-day functioning • **2-MODERATE** = Significant impact on quality of life and/or day-to-day functioning • **3-SEVERE** = Profound impact on quality of life and/or day-to-day functioning.

SYMPTOM LIST                      Scoring                      SYMPTOM LIST                      Scoring

Depressed Mood		Conduct Problems	
Appetite Disturbance		Oppositional Behavior	
Sleep Disturbance		Sexual Dysfunction	
Constipation disturbance		Grief	
Fatigue/Low Energy		Hopelessness	
Poor Concentration		Social Isolation	
Poor Grooming		Worthlessness	
Mood Swings		Guilt	
Agitation		Elevated Mood	
Emotionality		Hyperactivity	
Irritability		Easily Distracted	
Generalized Anxiety		Self Abuse/Injury	
Panic Attacks		Weight loss/gain	
Decreased Activity Levels		Emotional trauma victim	
Obsessions/Compulsions		Physical trauma victim	
Binging/Purging		Sexual trauma victim	
Laxative Abuse		Emotional trauma abuser	
Anorexia		Physical trauma abuser	
Paranoia		Sexual trauma abuser	
Circumstance symptoms		Substance abuse	
Racing Thoughts		Physical Complaints	
Delusions		Phobias	
Hallucinations		Other:	
Aggressive Behaviors			

### FAMILY HISTORY: check most appropriate answer

	Present entire childhood	Present part of childhood	Not present at all
Mother			
Father			
Step Mother			
Step Father			
Brother(s)			
Sisters(s)			
Other:			

**Describe childhood family experience: Check the most appropriate answer**

<input type="checkbox"/>	Outstanding home environment
<input type="checkbox"/>	Normal home environment
<input type="checkbox"/>	Chaotic home environment
<input type="checkbox"/>	Witnessed Physical/Verbal/sexual abuse toward others
<input type="checkbox"/>	Experienced physical/verbal/sexual abuse from others

**Special circumstances in childhood:** \_\_\_\_\_  
 \_\_\_\_\_

**Marital Status: Check all that apply**

<input type="checkbox"/>	Single, Never married
<input type="checkbox"/>	Engaged _____ months
<input type="checkbox"/>	Married for _____ years
<input type="checkbox"/>	Divorced for _____ years
<input type="checkbox"/>	Separated for _____ years
<input type="checkbox"/>	Divorce in process _____ months
<input type="checkbox"/>	____ Prior marriages (self)
<input type="checkbox"/>	____ Prior marriages (partner)

**Intimate Relationship: check one**

<input type="checkbox"/>	Never been in a relationship
<input type="checkbox"/>	Not currently in a relationship
<input type="checkbox"/>	Currently in a serious relationship

**Relationship Satisfaction: check one**

<input type="checkbox"/>	Very satisfied with relationship
<input type="checkbox"/>	Satisfied with relationship
<input type="checkbox"/>	Somewhat satisfied with relationship
<input type="checkbox"/>	Dissatisfied with relationship
<input type="checkbox"/>	Very dissatisfied with relationship

**Describe any past or current significant in intimate relationships:** \_\_\_\_\_  
 \_\_\_\_\_

**Describe and past or current significant issues in other immediate family relationships:** \_\_\_\_\_  
 \_\_\_\_\_

**Please List Medications, Dosage, and Frequency, and Prescriber:**

\_\_\_\_\_  
 \_\_\_\_\_

**Family alcohol/drug abuse history: check all that apply**

<input type="checkbox"/>	Father
<input type="checkbox"/>	Mother
<input type="checkbox"/>	Grandparent(s)
<input type="checkbox"/>	Stepparent/live in
<input type="checkbox"/>	Uncles/ Aunts
<input type="checkbox"/>	Siblings
<input type="checkbox"/>	Spouse/Significant other
<input type="checkbox"/>	Children

<input type="checkbox"/>	No history of abuse
<input type="checkbox"/>	Active abuse
<input type="checkbox"/>	Early full remission
<input type="checkbox"/>	Early partial remission
<input type="checkbox"/>	Sustained full remission
<input type="checkbox"/>	Sustained partial remission

**Substances used: (complete all that apply)**

	First age of use	Last age of use	Frequency	Amount
<b>Alcohol</b>				
<b>Amphetamines</b>				
<b>Barbiturates</b>				
<b>Caffeine</b>				
<b>Cocaine</b>				
<b>Crack cocaine</b>				
<b>Hallucinogens</b>				
<b>Inhalants</b>				
<b>Marijuana/hash</b>				
<b>Nicotine</b>				
<b>PCP</b>				
<b>Prescription</b>				
<b>Other:</b>				

**Delayed Developmental Milestones (check those that did not occur at expected age):**

<input type="checkbox"/>	Sitting
<input type="checkbox"/>	Rolling over
<input type="checkbox"/>	Standing
<input type="checkbox"/>	Walking
<input type="checkbox"/>	Controlling bowels
<input type="checkbox"/>	Sleeping alone
<input type="checkbox"/>	Dressing self
<input type="checkbox"/>	Engaging peers

<input type="checkbox"/>	Feeding self
<input type="checkbox"/>	Speaking words
<input type="checkbox"/>	Speaking sentences
<input type="checkbox"/>	Controlling bladder
<input type="checkbox"/>	Tolerating separation
<input type="checkbox"/>	Playing cooperatively
<input type="checkbox"/>	Riding tricycle
<input type="checkbox"/>	Riding bicycle

**Emotional/Behavioral Problems (check all that apply):**

	Drug Use
	Alcohol abuse
	Chronic lying
	Stealing
	Violent temper
	Repeats words of others
	Not trustworthy
	Hostile/Angry mood
	Indecisive
	Immature
	Distrustful
	Extreme Worrier
	Self-injurious acts
	Impulsive
	Easily distracted
	Fire setting
	Hyperactive
	Animal cruelty
	Assaults others
	Disobedient
	Bizarre Behavior
	Frequently tearful
	Frequently daydreams
	Lack of attachment
	Poor concentration
	Often sad
	Breaks things
	Bedwetting
	Paranoia
	Employment
	Peer Relationships
	Family Relationships
	Medications
	Academics
	Other: