The Stern Center
for Developmental and Behavioral Health

ADULT BIOPSYCHOSOCIAL – OUTPATIENT

Client Name: _____ Date: _____ Age: _____ DOB: _____

Nickname/Preferred Name: _____ Preferred Pronouns: _____

How did you hear about us? _____ Referral Source: _____

Address (Number and Street): _____ City: _____

State: _____ Zip Code: _____ Email: _____

Telephone Number: _____ Alternate Phone Number: _____

Which gender do you identify with: _____ Sexual Orientation: _____

Race: _____ Ethnicity: _____ Religion: _____

Are there any specific cultural considerations that would impact service delivery? Yes ☐ No ☐ If yes, please explain

_____

Do you require any assistive devices (sight, hearing, mobility) in order for services to be delivered appropriately? Yes ☐ No ☐

_____

_____

Therapist Completing Form: _____ Office Location: _____

Person(s) Participating in Evaluation _____

PSYCHOSOCIAL HISTORY

Birthplace: _____ As a child, lived at: _____

Client was raised by: *(Intact nuclear family vs. grandparents, stepparents, other relatives, adopted.)* _____

Details: _____

Number of Siblings: _____ Birth Order: _____ Number of Step Siblings: _____

Please note significant relationships or concerns: _____

_____

Pregnancy and Delivery Were: (circle one) Normal ◉ Uncomplicated ○ Complicated ○

If Complicated, Please Explain:_____

_____

Was the client exposed to drugs or alcohol in-utero? Yes ☐ No ☐ If yes, what drug?_____

Developmental Milestones Were: (circle one) Usual time ◉ Early ○ Late ○

Specify:_____

Please indicate any unusual childhood illness/injuries, or surgeries (broken bones, high fevers, hospitalization, head injuries, etc.)

_____

_____

Have you ever been married? **Yes** or **No** If yes, how many times?_____

Details:_____

Have you ever been pregnant? Yes If yes, how many times?_____ Number of children_____

Details about unsuccessful pregnancies:

_____

_____

Names and ages of children: _____

Do you have custody of your children? ☐ Yes ☐ No

Name of parent/guardian with custody of children_____ Medical Rights _____

If your child is adopted:

Age when child first in home: _____ Date of legal adoption: _____

What has the child been told? _____

Was the child ever placed, boarded, or lived away from the family? ☐ Yes ☐ No

Explain:_____

Please describe the child's relationship with immediate family members:_____

_____

Relationship with siblings: _____

What are the major family stresses at the present time, if any?

_____

_____

_____

Any other details:

_____

CURRENT LIVING SITUATION

LIST HOUSEHOLD MEMBERS

NAME	AGE	RELATIONSHIP

Describe relationship(s) with parents/siblings/extended family members:

_____

_____

_____

Recent Family Stressors:

_____

_____

Current Support System:

_____

FAMILY OF ORIGIN

Biological Mother's Name:_____

What is your current relationship with her?_____

Biological Father's Name:_____

What is your current relationship with him?_____

Did you at any time live with persons other than your biological parents? Yes☐ No☐ If Yes, please note whom, why and their current relationship to you:_____

_____

Family Problems *(include domestic violence, finances, divorce, physical/emotional/sexual abuse, family discord, instability of residence, suicide, self-injury etc.)*:

_____

_____

_____

FAMILY HISTORY

Circle all that apply: Heart Disease ☐ Thyroid Disorder ☐ Diabetes ☐ Migraines ☐ Pulmonary Disorder ☐

Cancer ☐ Arthritis ☐ Seizure Disorder ☐ Other:_____

Mental Health

Type of Illness	Family Member	Services Involved

Substance Use (Include Prescription Medications and alcohol)

Type of Drug	Family Member	Services Involved

PERSONAL MEDICAL HISTORY

Family Doctor: _____ Date of Last Physical: _____BMI:_____

ALLERGY INFORMATION

TYPE OF ALLERGY	TYPE OF REACTION

Are you currently on, or have ever been on any physical health medication? Yes ☐ No ☐
If yes please complete below

Medication & Dosage	Condition Prescribed For	Start/Discontinued

How well do you believe these medications addressed what they were prescribed for?

_____

_____

Please list any over the counter medicines or supplements that you are currently taking:

_____

_____

Please list any previous health conditions and or significant medical events: *(include injuries, illness, surgeries, etc.)*:

_____

_____

How would you describe your current level of functioning in daily activities: _____

_____

Recent Appetite Change (circle): None Decrease Increase

Weight Change (circle): None Decrease Increase

Sleep Disturbance (circle all that apply): None Restless Decrease Difficulty falling asleep Waking too early Nightmares Other:_____

Sexual Activity (circle): Active Not Active Interest No Interest

Change in Sexual Activity (circle): Same Increase Decrease

BEHAVIORAL HEALTH INFORMATION

Have you ever previously been diagnosed with mental health or substance use condition? Yes___ No___

If yes, please list which diagnosis:_____

_____

Have you ever received mental health treatment? Yes___ No___, if yes, please complete below;

Type of Service	Location	Duration of Service

EDUCATIONAL INFORMATION

Are you currently enrolled in school/educational program? Yes☐ No☐

If yes, name of school_____

Current Level (Grade)_____ Are there any current educational concerns?_____

_____

Please list education history:

Name of Facility	**Years enrolled/Grade or Level**	**Notes(include problems, degrees, etc)**

EMPLOYMENT HISTORY

Have you ever been employed? Yes☐ No☐

If No, what is your source of income?_____

Are you currently employed? Yes☐ No☐

If No, _____

Employers:

Name	Timeframe	Reason for leaving

Previous military history?_____

LEGAL HISTORY

Please indicate any legal involvement, including dates, outcomes and pending issues:

_____

_____

OTHER SYSTEMS INVOLVED

Is CYS currently involved with your family? Yes☐ No☐ If yes, what county?_____

Who is your caseworker?_____

What is the current status of your case?_____

Are there any other systems involved? Yes☐ No☐, if yes complete below.

Company Name	Service Line	Who is the IP?	Contact Name (obtain ROI)

SELF ASSESSMENT

What do you view as your personal strengths:

_____

_____

What is happening in your life which resulted in this appointment:

_____

_____

What would you like to see accomplished in therapy:

_____

_____

How do you generally handle problems?

_____

_____

How would you describe how you have adjusted psychologically and socially to your diagnosis and/or disorder?

_____

_____

What are your personal interests and or abilities:

_____

_____

Do you have any personal preferences:

_____

_____

What do you do during your unstructured time?

_____

_____

What family involvement would you like to see in therapy?

_____

_____

NATURAL SUPPORTS (COMMUNITY, FAMILY, FRIENDS)

Are you involved in any community activities/ organizations? Yes ☐ No ☐

If Yes, what are they and how often are you involved?_____

If No, what would you like to be involved in?_____

Who do you confide in?_____

Do you feel you have or need social supports, please describe;_____

How would you describe your friendships? stable ☐ mutual ☐ volatile ☐ inconsistent ☐ dependent ☐

Other:_____

PRESENTING PROBLEM:

SYMPTOMS

1._____

Onset: _____ Frequency: _____ Durations: _____

2._____

Onset: _____ Frequency: _____ Durations: _____

3._____

Onset: _____ Frequency: _____ Durations: _____

CURRENT PRESCRIBED MENTAL HEALTH MEDICATIONS

1._____ Dose:_____ Frequency: _____

Prescribed By: _____ Since: _____

2._____ Dose:_____ Frequency: _____

Prescribed By: _____ Since: _____

3._____ Dose:_____ Frequency: _____

Prescribed By: _____ Since: _____

Do you use over the counter medications? Supplements?

_____

_____

Is There a History of Self-Harm or Suicidal Behavior? ☐ Yes ☐ No

Are you thinking about hurting yourself or others today? _____

Do you have access to firearms? ☐ Yes ☐ no

If Yes, Please Explain how the firearms are stored: _____

SUBSTANCE USE HISTORY

MISA Screening and Assessment

1. Does the client use of drugs or alcohol? ☐ Yes ☐ No
2. Does anyone in your family use drugs or alcohol? ☐ Yes ☐ No
3. Do you drink beverages that contain caffeine? ☐ Yes ☐ No

   Describe frequency:_____
4. Do you use tobacco products? ☐ Yes ☐ No

   Describe type and frequency:_____
5. Have you used alcohol or drugs in the past? ☐ Yes ☐ No
6. Are you using alcohol or drugs at this time? ☐ Yes ☐ No
7. Are there visible signs of intoxication? ☐ Yes ☐ No

If there is a yes response to numbers 1,5,6, or 7, complete the following MISA assessment.

MISA Assessment

Substance	Quantity	Frequency of Use	Route	First Use	Last Use

Describe the Progression of use. (This includes the sequence of first use of substances, periods of abstinence, combination of use and any relevant comments)_____

_____

Has client ever become annoyed when asked about drugs or alcohol? ☐ Yes ☐ No

Has client avoided other activities because of drugs or alcohol use? ☐ N/A ☐ No ☐ Yes

Explain _____

Does client believe that drug & alcohol use has negatively affected life? (own or someone else's usage)

☐ N/A ☐ No ☐ Yes How so?_____

Does client have any history of treatment for drugs or alcohol abuse? ☐ No ☐ Yes, please describe the following:

Type of Treatment	Where	For How Long	Voluntary?	Was Treatment Effective? Explain

AA/NA Involvement? ☐ No ☐ Yes ☐ Voluntary ☐ Mandated Regular Attendance? ☐ Yes ☐ No

TRAUMA/ SIGNIFICANT EVENT SCREENING

☐ Check box if no trauma history.

Please indicate yes or no, if yes explain.

History of out of home placement ☐ **Yes** ☐ **No**

yes:_____

History of abuse (circle: sexual, physical, emotional) ☐ **Yes** ☐ **No**

yes:_____

History of neglect ☐ **Yes** ☐ **No**

yes:_____

Domestic violence by history or current ☐ **Yes** ☐ **No**

yes:_____

Victim/ Witness to Criminal Activity/ Community Violence ☐ **Yes** ☐ **No**

yes:_____

Direct Experience with Natural or Manmade Disasters ☐ **Yes** ☐ **No**

yes:_____

Extensive Medical Needs and/or Procedures ☐ **Yes** ☐ **No**

yes:_____

Drug and Alcohol use by history or current ☐ **Yes** ☐ **No**

yes:_____

Significant family Mental Health issues by history or current ☐ **Yes** ☐ **No**

yes:_____

Significant losses (death, fire, accident) ☐ **Yes** ☐ **No**

yes:_____

Absence of biological caretaker (regardless of cause) ☐ **Yes** ☐ **No**

yes:_____

To what degree do you feel that the identified adverse events negatively impact your level of functioning?

☐ **Not at all** ☐ **Slightly** ☐ **Moderately** ☐ **Very much** ☐ **Extremely**

Does the client experience: ☐ Flashbacks ☐ Memories

If yes please describe?_____

MENTAL STATUS EXAM

A. Appearance: ☐ WNL ☐ Unkempt ☐ Dirty ☐ Meticulous ☐ Unusual

B. Behavior: ☐ WNL ☐ Guarded ☐ Withdrawn ☐ Hostile ☐ Noncompliant ☐ Hyperactive ☐ Suspicious ☐ Cooperative ☐ Unpleasant

C. Cognitions: ☐ WNL ☐ Loose ☐ Scattered ☐ Blocked ☐ Illogical ☐ Delusional ☐ Paranoid ☐ Somatic ☐ Hallucinations ☐ Grandiose ☐ Fragmented

D. Mood/Affect: ☐ WNL ☐ Flat ☐ Depressed ☐ Euphoric

E. Safety:

Danger to self/others? ☐ Yes ☐ No If yes, describe:_____

Safe to return home? ☐ Yes ☐ No If no, describe action taken:_____

SNAP

Strengths:_____

Needs:_____

Abilities: _____

Preferences:_____

TREATMENT RECOMMENDATIONS

Diagnosis: _____

_____

Level of Care: _____

_____

Parent/Guardian Signature:_____Date:_____

Client Signature: _____Date: _____

Therapist Signature: _____Date: _____

Interpretive Summary

Therapist signature: _____ **Date:**_____