321 N Devilliers St. Suite 209 Pensacola, FL 32501 www.RealityCheckCS.com

Client Name ___________________________ Client ID# __________________ Date ________

BIOPSYCHOSOCIAL HISTORY INTAKE FORM

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning • **Moderate** = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]
guilt	[ ]	[ ]	[ ]	[ ]	appetite disturbance	[ ]	[ ]	[ ]	[ ]
laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]
hyperactivity	[ ]	[ ]	[ ]	[ ]	elimination disturbance	[ ]	[ ]	[ ]	[ ]
paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]
somatic complaints	[ ]	[ ]	[ ]	[ ]	psychomotor retardation	[ ]	[ ]	[ ]	[ ]
loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]
unusual weight gain/loss	[ ]	[ ]	[ ]	[ ]	poor grooming	[ ]	[ ]	[ ]	[ ]
hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]
emotional trauma victim	[ ]	[ ]	[ ]	[ ]	agitation	[ ]	[ ]	[ ]	[ ]
conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]
sexual trauma victim	[ ]	[ ]	[ ]	[ ]	irritability	[ ]	[ ]	[ ]	[ ]
sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]
substance abuse	[ ]	[ ]	[ ]	[ ]	obsessions/compulsions	[ ]	[ ]	[ ]	[ ]
worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify)	[ ]	[ ]	[ ]	[ ]

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] No [ ] Yes **Prior outpatient psychotherapy?**
If yes, on ____ occasions. Longest treatment by ____________ (Provider Name) for sessions from __/____ (Mo/Yr) to __/____ (Mo/Yr)

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
__________________	______	_____	_______	__________	_____________________	_______
__________________	______	_____	_______	__________	_____________________	_______

[ ] No [ ] Yes **Has any family member had outpatient psychotherapy?** If yes, who/why (list all): ______________
____

[ ] No [ ] Yes **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**
If yes, on _________occasions. Longest treatment at __________________ (Name of facility) from __/____ (Mo/Yr) to __/____ (Mo/Yr)

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial
___________________	______	____	___________	___________	_________________________	________
___________________	______	____	___________	___________	_________________________	________

[ ] No [ ] Yes **Has any family member had inpatient treatment for a psychiatric, emotional, or substance use d/o? If yes,** who/why (list all): ____

[ ] No [ ] Yes **Prior or current psychotropic medication usage?** If yes:

Medication	Dosage Freq	Start date	End date	Physician	Side effects	Beneficial?
_____________	__________	________	________	_____________	____________	_________
_____________	__________	________	________	_____________	____________	_________
_____________	__________	________	________	_____________	____________	_________
_____________	__________	________	________	_____________	____________	_________

[ ] No [ ] Yes **Has any family member used psychotropic medications?** If yes, who/what/why (list all):

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

____

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ____years
[ ] mother remarried ____ times
[ ] father remarried ____ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of client at mother's death ___
[ ] father deceased for ___ years
age of client at father's death ___

Client Name: Client ID:

Describe childhood family experience:
[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _______ **Circumstances:** ____
____
____

Special circumstances in childhood: ____
____
____

IMMEDIATE FAMILY

Marital status:
[ ] single, never married
[ ] engaged _____ months
[ ] married for ____ years
[ ] divorced for ____ years
[ ] separated for ____ years
[ ] divorce in process ____ months
[ ] live-in for ___years
[ ] ___ prior marriages (self)
[ ] ___ prior marriages (partner)

Intimate relationship:
[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:
[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in client's household:

Name	Age	Sex	Relationship to client
_________________	____	___	___________________
_________________	____	___	___________________
_________________	____	___	___________________
_________________	____	___	___________________

List children not living in same household as client:

Name	Age	Sex	Relationship to client
_________________	____	___	___________________
_________________	____	___	___________________
_________________	____	___	___________________
_________________	____	___	___________________

Frequency of visitation of above: _______________________________

Describe any past or current significant issues in <u>intimate</u> relationships: ________________________________
____
____

Describe any past or current significant issues in other <u>immediate family</u> relationships: ____________________
____
____

Client Name: Client ID:

MEDICAL HISTORY (check all that apply for client)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor
____
____

List name of primary care physician:
Name ______________________ Phone _________________

List name of psychiatrist: (if any):
Name______________________ Phone __________________

Is there a history of any of the following in the family:

[ ] tuberculosis
[ ] birth defects
[ ] emotional problems
[ ] behavior problems
[ ] mental retardation
[ ] Alzheimer's disease/dementia
[ ] thyroid problems
[ ] other chronic or serious health problems _________
____
[ ] heart disease
[ ] high blood pressure
[ ] alcoholism
[ ] drug abuse
[ ] stroke
[ ] cancer
[ ] diabetes

List any medications currently being taken (give dosage & reason):
____
____
____

Describe any serious hospitalization or accidents:
Date ________ Age ___ Reason ______________________________________
Date ________ Age ___ Reason ______________________________________
Date ________ Age ___ Reason______________________________________

List any known allergies: ______________________________________

List any abnormal lab test results:
Date _______ Result ________________________________
Date _______ Result________________________________

SUBSTANCE USE HISTORY (check all that apply for client)

Family alcohol/drug abuse history:

[ ] father
[ ] mother
[ ] grandparent(s)
[ ] sibling(s)
[ ] other
[ ] stepparent/live-in
[ ] uncle(s)/aunt(s)
[ ] spouse/significant other
[ ] children

Substance use status (client):

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used: (complete all that apply)	First use age	Last use age	**Current Use** (Yes/No)	Frequency	Amount
[ ] alcohol	________	________	______	________	________
[ ] amphetamines/speed	________	________	______	________	________
[ ] barbiturates/owners	________	________	______	________	________
[ ] caffeine	________	________	______	________	________
[ ] cocaine	________	________	______	________	________
[ ] crack cocaine	________	________	______	________	________
[ ] hallucinogens (e.g., LSD)	________	________	______	________	________
[ ] inhalants (e.g., glue, gas)	________	________	______	________	________
[ ] marijuana or hashish	________	________	______	________	________
[ ] nicotine/cigarettes	________	________	______	________	________
[ ] PCP	________	________	______	________	________
[ ] prescription	________	________	______	________	________
[ ] other	________	________	______	________	________

Treatment history:
[ ] outpatient (age[s] _____)
[ ] inpatient (age[s] ______)
[ ] 12-step program (age[s] __)
[ ] stopped on own (age[s] ___)
[ ] other (age[s]
describe: ____

Consequences of substance abuse (check all that apply):
[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other ____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:
[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:
[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications
____
birth weight ___lbs ____ oz.

Infancy:
[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:
[ ] chickenpox (age __) [ ] lead poising (age__)
[ ] German measles (age __) [ ] mumps (age ___)
[ ] red measles (age __) [ ] diphtheria (age ___)
[ ] rheumatic fever (age ___) [ ] poliomyelitis (age _)
[ ] whooping cough (age ___) [ ] pneumonia (age __)
[ ] scarlet fever (age __) [ ] tuberculosis (age _)
[ ] autism [ ] mental retardation
[ ] ear infections [ ] asthma
[ ] allergies to ________________________________
[ ] significant injuries ___________________________
[ ] chronic, serious health problems _______________
____

Delayed developmental milestones (check only those milestones that did not occur at expected age):
[ ] sitting [ ] controlling bowels
[ ] rolling over [ ] sleeping alone
[ ] standing [ ] dressing self
[ ] walking [ ] engaging peers
[ ] feeding self [ ] tolerating separation
[ ] speaking words [ ] playing cooperatively
[ ] speaking sentences [ ] riding tricycle
[ ] controlling bladder [ ] riding bicycle
[ ] other _____________

Emotional / behavior problems (check all that apply):
[ ] drug use [ ] repeats words of others [ ] distrustful
[ ] alcohol abuse [ ] not trustworthy [ ] extreme worrier
[ ] chronic lying [ ] hostile/angry mood [ ] self-injurious acts
[ ] stealing [ ] indecisive [ ] impulsive
[ ] violent temper [ ] immature [ ] easily distracted
[ ] fire-setting [ ] bizarre behavior [ ] poor concentration
[ ] hyperactive [ ] self-injurious threats [ ] often sad
[ ] animal cruelty [ ] frequently tearful [ ] breaks things
[ ] assaults others [ ] frequently daydreams [ ] other __________
[ ] disobedient [ ] lack of attachment ___________________

Social interaction (check all that apply):
[ ] normal social interaction [ ] inappropriate sex play
[ ] isolates self [ ] dominates others
[ ] moderate retardation [ ] very shy
[ ] learning problems [ ] underachieving
[ ] alienates self [ ] other ____________

Intellectual / academic functioning (check all that apply):
[ ] normal intelligence [ ] authority conflicts
[ ] high intelligence [ ] attention problems
[ ] associates with acting-out peers [ ] mild retardation
[ ] severe retardation
Current or highest education level ____________________________

Describe any other developmental problems or issues: ____
____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:
[ ] housing adequate
[ ] homeless

Social support system:
[ ] supportive network
[ ] few friends

Sexual history:
[ ] heterosexual orientation [ ] currently sexually dissatisfied
[ ] homosexual orientation [ ] age first sex experience

Client Name: Client ID:

[ ] housing overcrowded
[ ] age first pregnancy/fatherhood
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] history of unsafe sex age __ to ___

[ ] substance-use-based friends
[ ] dependent on others for housing
[ ] history of promiscuity age __ to ___
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

[ ] bisexual orientation
[ ] no friends
[ ] currently sexually satisfied
[ ] distant from family of origin
Additional information: _________

Employment:
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled: _________

Military history:
[ ] never in military
[ ] served in military - no incident
[ ] served in military - with incident

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income total time served:
[ ] impulsive spending describe last legal difficulty:
[ ] relationship conflicts over finances

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison time(s)

Cultural/spiritual/recreational history:
Cultural identity (e.g., ethnicity, religion): ____
Describe any cultural issues that contribute to current problem: ____
____

Currently active in community/recreational activities?	Yes [ ]	No [ ]
Formerly active in community/recreational activities?	Yes [ ]	No [ ]
Currently engage in hobbies?	Yes [ ]	No [ ]
Currently participate in spiritual activities?	Yes [ ]	No [ ]

If answered "yes" to any of above, describe: ____
____

SOURCES OF DATA PROVIDED ABOVE: [ ] Patient self-report for all [ ] A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms
[ ] patient self-report
[ ] patient’s parent/guardian
[ ] other (specify) ____________

Family History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ____________

Developmental History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) ________________

Emotional/Psychiatric History
[ ] patient self-report
[ ] patient’s parent/guardian
[ ] other (specify) ______________

Medical/Substance Use History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _______________

Socioeconomic History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) __________________

Client Name:

Client ID: