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Biopsychosocial Assessment

Please answer the following questions honestly to the best of your ability

Name: _____

DOB: _____ **Age:** _____

Address: _____

Telephone: _____ **Cell:** _____

Occupation: _____ **Work Phone:** _____

Employer: _____

Education: _____

Spouses Name (if married): _____

How long married or date of divorce: _____

Children and ages: _____
***Please include any problems that occurred during pregnancy or delivery or present concerns**

_____

_____

Parents name and age (if deceased, date of death & cause): _____
***Please also include any history of physical or mental illness**

Mother: _____ **Father:** _____

Step Parents: _____ _____

_____

Siblings names and ages (if deceased, date of death & cause): _____
***Please also include any history of physical or mental illness**

_____

_____

Purpose of seeking counseling: _____

_____

_____

_____

How long has this been a problem for you?: _____

_____

Present state of health (include hospitalizations, surgeries and all medications:
***Please list all medications, over the counter and prescription, dosage, who is prescribing them - continue on back if necessary**

_____

_____

_____

Name and phone number of primary care doctor: _____

Social hobbies, interests and support system: _____

Psychiatric history (Please include previous psychotherapy, medications, hospitalizations and suicide attempts) :
***Please include whether you felt the therapy/treatment was successful**

Family history:_____
***parent/sibling relationships, history of sexual, physical abuse or anything you feel is important to share**

Please rate your overall satisfaction in the following areas of your life using this scale:

1	2	3	4	5
Poor	Somewhat Satisfied	Average	Great	Excellent

1. **Satisfaction with your career** _____
2. **Satisfaction with your body/weight** _____
3. **Satisfaction with yourself overall** _____
   ***Self Esteem**
4. **Satisfaction with your partner** _____
5. **Satisfaction with your sex life** _____
6. **Satisfaction with your parenting** _____
7. **Satisfaction with extended family** _____

What are the 3 goals that you wish to accomplish from counseling?: _____

_____

_____

_____

How long do you expect to remain in counseling to achieve your goals?: _____

_____

Any additional information that is pertinent: _____
***continue on reverse if needed**

_____

Client Signature:_____ **Date:**_____

Printed Name:_____