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BioPsychosocial Assessment

Demographic Information

Name (Last, First, and Middle)_____ Date: _____
Date of Birth (MM/DD/YYYY) _____ Age: _____
Gender assigned at birth: ☐Male ☐Female ☐Other: _____
Current Gender Expression: ☐Male ☐Female ☐Other: _____
Address: _____
Phone Number: _____ Okay to Leave a Message? ☐Yes ☐No

Race/Ethnicity: _____ Preferred Language: _____ Culture: _____
Sexual Orientation: _____ Preferred Choice of Sexual Partners: ☐Male ☐Female ☐Both

Living Arrangement: ☐Homeless ☐Independent living ☐Other (specify): _____
Have you been in a controlled environment in the past 30 days (e.g. Jail, Hospital, Treatment) ☐Yes ☐No
(specify) _____

Explanation of why patient is currently seeking treatment: Current symptoms, functional impairment, severity, duration of symptoms (e.g., unable to work/school/relationship/housing problems):

_____

_____

What does the patient hope to get from treatment? (in patients own words):

_____

_____

Personal/Social HIstory

Religion/Spirituality/Faith Background ☐Yes ☐No (specify) _____
Currently Practice? ☐Active ☐None

Highest Grade Completed in school: _____ GED ☐Yes ☐No ☐N/A
If you did not graduate explain why: _____
Do you currently have any or ever had any behavioral, learning disabilities, or traumatic experiences that are significant to educational history? ☐Yes ☐No (explain) _____

Do you need assistance with Reading/Writing ☐Yes ☐No (specify) _____
Will this have an adverse affect on your ability to receive counseling? ☐Yes ☐No (explain) _____
_____
Do you use any assistive devices (e.g. Wheelchair, walking devices, hearing aids, etc) ☐Yes ☐No
(specify) _____
Military Service ☐Yes ☐No (specify which branch, length of service and discharge type): _____
_____
Do you have an Advance Directive ☐Yes ☐No

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Family History

Member	Name	Age/ deceased?	History of alcohol or drug issues or mental illness?(specify)	Quality of relationship
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Who were you raised by? ☐Parents ☐One Parent ☐Relatives ☐Foster ☐Adoptive
Describe your childhood (e.g. home atmosphere, moved a lot)? _____
_____
Type of residence you grew up in _____ Economic Status _____

Any developmental issues while growing up (e.g. developmental milestones such as crawl/walk/talk on time ☐Yes ☐No ☐Unsure (specify) _____
Are you aware of any pregnancy or delivery issues ☐Yes ☐No ☐Unsure (specify) _____
What types of things do you like to do for fun? _____
Do you have any children (list names and ages) ☐Yes ☐No _____
_____

What are your:
Strengths _____
Needs_____
Abilities_____
Preferences_____

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Dimension 1: Substance Use, Acute Withdrawal and/or Withdrawal Potential

1. Substance use history:

Alcohol or Drug Type	Recently Used? (past 6 months)	Prior Use (Lifetime)	Route (inject, smoke, snort)	Amount used	Age at first use?	Current Frequency (daily, weekly, monthly)	Duration (length of use)	Date of last use
Amphetamines (meth, ice, crank)	☐	☐						
Alcohol	☐	☐						
Cocaine/Crack	☐	☐						
Heroin	☐	☐						
Marijuana	☐	☐						
Opioid Pain Medications *misuse or without a prescription*	☐	☐						
Sedative (Benzos, sleeping pills) *misuse or without a prescription*	☐	☐						
Hallucinogens	☐	☐						
Inhalants	☐	☐						
Over the counter medication (cough syrup, diet aids)	☐	☐						
Nicotine	☐	☐						
Other:	☐	☐						

Additional Information: _____

_____

_____

2. Do you find yourself using more alcohol and/or drugs than you intend to? ☐Yes ☐No

Please describe: _____

_____

3. Do you get physically ill when you stop using alcohol and/or drugs? ☐Yes ☐No

Please describe:_____

_____

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4. Are you currently experiencing withdrawal symptoms, such as tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting, etc.? ☐Yes ☐No
Please describe specific symptoms: _____
_____
_____

5. Do you have a history of serious withdrawal, seizures, or life-threatening symptoms during withdrawal?
☐Yes ☐No
Please describe and specify withdrawal substance(s):_____
_____

6. Do you find yourself using more alcohol and/or drugs in order to get the same high? ☐Yes ☐No
Please describe:_____

7. Has your alcohol and/or drug use changed recently (increase/decrease, changed route of use)?
☐Yes ☐No
Please describe: _____

9. Have any of your family members been to treatment for alcohol and/or drug use (specify who and when):_____
_____

Please circle one of the following levels of severity

Severity Rating- Dimension 1 (Substance Use, Acute Withdrawal and/or Withdrawal Potential)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
No signs of withdrawal/intoxication present ☐	Mild/moderate intoxication, interferes with daily functioning. Minimal risk of severe withdrawal. No danger to self/others. ☐	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others. ☐	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal. ☐	Incapacitated. Severe signs and Symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life. ☐

Additional Comments: _____
_____
_____

Dimension 2: Biomedical Conditions and Complications

10. Please list Medical Provider(s):

Physician Name	Specialty	Contact Information

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11. Do you have any of the following medical conditions:

☐Heart Problems ☐Seizure/Neurological ☐Muscle/Joint Problems ☐Diabetes
☐High Blood Pressure ☐Thyroid Problems ☐Vision Problems ☐Sleep Problems
☐High Cholesterol ☐Kidney Problems ☐Hearing Problems ☐ Chronic Pain
☐Blood Disorder ☐Liver Problems ☐Dental Problems ☐Pregnant
☐Stomach/Intestinal Problems ☐Asthma/Lung Problems ☐Sexually Transmitted Disease(s):
☐Cancer (specify types[s]): _____ ☐Infection(s):_____
☐Allergies: _____ ☐Other:

12. Do any of these conditions significantly interfere with your life? ☐Yes ☐No
Please describe: _____
_____

13. Provide additional comments on medical conditions, prior hospitalizations (include dates and reasons): _____
_____
_____

14. Question to be answered by interviewer: Does the client report medical symptoms that would be considered life-threatening or require immediate medical attention? ☐Yes ☐No
** If yes, consider immediate referral to emergency room or call 911*

15. List current medication(s) for medical condition(s):

Medication	Dose/Frequency	Reason	Effectiveness/Side Effects

16. Do any of your family members have a history of medical problems (Specify whom and what): _____
_____

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Please circle one of the following levels of severity

Severity Rating- Dimension 2 (Biomedical Conditions and Complications)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
Fully functional/ able to cope with discomfort or pain. ☐	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort. ☐	Some difficulty tolerating physical problems. Acute, nonlife-threatening problems present, or serious biomedical problems are neglected. ☐	Serious medical problems neglected during outpatient or intensive outpatient treatment. Severe medical problems are present but stable. Poor ability to cope with physical problems. ☐	incapacitated with severe medical problems ☐

Additional Comments: _____

_____

_____

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

15. Do you consider any of the following behaviors or symptoms to be problematic?

Mood

☐Depression/sadness ☐Loss of Pleasure/Interest ☐Hopelessness ☐Irritability/Anger
☐Impulsivity ☐Pressured Speech ☐Grandiosity ☐Racing Thoughts

Anxiety

☐Anxiety/Excessive Worry ☐Obsessive Thoughts ☐Compulsive Behaviors ☐Flashbacks

Psychosis

☐Paranoia ☐Delusions:_____ ☐ Hallucinations:_____

Other

☐Sleep Problems ☐Memory/Concentration ☐Gambling ☐Risky Sex Behaviors
☐ Were the Risky Sexual Behaviors done while under the influence of alcohol and/or drugs: ☐Yes ☐No
☐Suicidal Thoughts: please describe_____
☐Thoughts of Harming Others: please describe_____
☐Experienced Abuse (specify: physical, emotional, sexual, neglect):_____
☐ Witnessed Abuse (specify: physical, emotional, sexual, neglect)_____
☐Traumatic Event(s):_____
☐Other:_____

16. Have you ever been diagnosed with a mental illness? ☐ Yes ☐No ☐Not Sure

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Please describe (e.g. diagnosis, medications?): _____

_____

17. Are you currently or have you previously received treatment for psychiatric or emotional problems?
☐Yes ☐No Please describe (e.g., treatment setting, hospitalizations, duration of treatment): _____

_____

18. Do you ever see or hear things that other people say they do not see or hear? ☐ Yes ☐No
Please describe: _____

19. Question to be answered by interviewer: Based on previous questions, is further assessment of mental health needed? ☐Yes ☐No
Please describe: _____

20. List current medication(s) for psychiatric condition(s):

Medication	Dose/Frequency	Reason	Effectiveness/Side Effects

21. Please list mental health Provider(s):

Physician Name	Contact Information

Please circle one of the following levels of severity

Severity Rating- Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
Good impulse control and coping skills. No dangerousness, good social functioning and self-care, no interference with recovery. ☐	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment. ☐	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning. ☐	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting ☐	incapacitated with severe medical problems ☐

Additional Comments: _____

_____

_____

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Dimension 4: Readiness to Change

22. Is your alcohol and/or drug use affecting any of the following?

☐ Work ☐Mental Health ☐Physical Health ☐Finances
☐ School ☐Relationships ☐Sexual Activity ☐Legal Matters
☐ Handling Everyday Tasks ☐Self-esteem ☐Hygiene ☐Recreational Activities
☐ Other: _____

Explain _____

23. Do you continue to use alcohol or drugs despite having it affect the areas listed above? ☐Yes ☐No

Please describe: _____

_____

24. Have you received help for alcohol and/or drug problems in the past? ☐Yes ☐No

Please list treatmentProvider(s):

Facility or Physician Name	Contact Information

25. What would help to support your recovery _____

_____

26. What are potential barriers to your recovery (e.g., financial, transportation, relationships, etc.)? _____

_____

27. How important is it for you to receive treatment for:

Alcohol Problems: ☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely
Drug Problems: ☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely
Please describe: _____

28. Internal Motivators_____

29. Eternal Motivators _____

30. <u>Question to be answered by interviewer:</u> Stage of change _____

Please circle one of the following levels of severity

Severity Rating- Dimension 4 (Readiness to Change)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
Insight and judgement are intact regarding problem and recovery. ☐	Slight insight into the problem. Ambivalent to the need to change. ☐	Reluctant to change substance use. Passive engagement in treatment. Lacks appropriate insight into the problem. ☐	Unaware of the need to change. Resistant to follow through with recommendations for treatment. Complete lack of insight into problems. ☐	Unwilling/unable to follow through with treatment recommendations. ☐

Additional Comments: _____

_____

_____

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Dimension 5: Relapse, Continued Use, or Continued Problem Potential

31. In the last 30 days, how often have you experienced cravings, withdrawal symptoms, disturbing effects of use?

Alcohol: ☐None ☐Occasionally ☐Frequently ☐Constantly

Drug: ☐None ☐Occasionally ☐Frequently ☐Constantly

32. Do you find yourself spending time searching for alcohol and/or drugs, or trying to recover from its effects? ☐Yes ☐No

Please describe: _____

33. Do you feel that you will either relapse or continue to use without treatment or additional support?

☐Yes ☐No

Please describe: _____

34. Are you aware of your triggers to use alcohol and/or drugs? ☐Yes ☐No

Please check off any triggers that may apply:

☐ Strong Cravings ☐ Work Pressure ☐ Mental Health ☐ Relationship Problems

☐ Financial Stressors ☐ Physical Health ☐ School Pressure ☐ Environment

☐ Unemployment ☐ Chronic Pain ☐ Peer Pressure ☐ Difficulty Dealing with Feelings ☐ Other _____

35. What do you do if you are triggered? _____

_____

36. Can you please describe any attempts you have made to either control or cut down on your alcohol and/or drug use?_____

_____

37. What is the longest period of time that you have gone without using alcohol and/or drugs?_____

_____

38. What helped and didn't help?_____

_____

Please circle one of the following levels of severity

Severity Rating- Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
Low/no potential for relapse. Good ability to cope. ☐	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills. ☐	Impaired recognition of risk for relapse. Able to self-manage with prompting. . ☐	Little recognition of risk for relapse, poor skills to cope with relapse. ☐	No coping skills for relapse/addiction problems.Substance use/behavior, places self/other in imminent danger. ☐

Additional Comments: _____

_____

_____

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Dimension 6: Recovery/Living Environment

39. Do you have any relationships that are supportive of your recovery? (e.g., family, friends) _____

_____

_____

40. What is your current living situation (e.g., homeless, living with family/alone)?_____

_____

41. Do you currently live in an environment where others are using drugs? ☐Yes ☐No
Please describe:_____

_____

42. Are you currently involved in relationships or situations that pose a threat to your safety? ☐Yes ☐No
Please describe: _____

_____

43. Are you currently involved in relationships or situations that would negatively impact your recovery?
☐ Yes ☐No
Please describe: _____

44. Are you currently employed or enrolled in school? ☐ Yes ☐No
Please describe (e.g., where employed, duration of employment, name and type of school): _____

_____

Past Employment History (where and for how long): _____

_____

45. Are you currently involved with social services or the legal system (e.g., DCFS, court mandated, probation, parole)? ☐ Yes ☐No
Please describe: _____

If on parole or probation:

Name of parole or probation officer	Contact Information

Please circle one of the following levels of severity

Severity Rating- Dimension 6 (Recovery/Living Environment)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
Able to cope in environment/ supportive. ☐	Passive/disinterested social support, but still able to cope. ☐	Unsupportive environment, but able to cope with clinical structure most of the time. ☐	Unsupportive environment, difficulty coping even with clinical structure. ☐	Environment toxic/hostile to recovery. Unable to cope and the environment may pose a threat to safety. ☐

Additional Comments: _____

_____

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Diagnosis: DSM-V Criteria for Substance Use Disorder

	Substance Use Disorder Criteria	#1	#2	#3
1	Substance often taken in larger amounts or over a longer period than was intended	☐	☐	☐
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	☐	☐	☐
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	☐	☐	☐
4	Craving, or a strong desire or urge to use the substance.	☐	☐	☐
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	☐	☐	☐
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance	☐	☐	☐
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.	☐	☐	☐
8	Recurrent substance use in situations in which it is physically hazardous.	☐	☐	☐
9	Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.	☐	☐	☐
10	Tolerance, as defined by either of the following: - A need for markedly increased amounts of the substance to achieve intoxication or desired effect. - A markedly diminished effect with continued use of the same amount of the substance	☐	☐	☐
11	Withdrawal, as manifested by either of the following: - The characteristic withdrawal syndrome for the substance. - Substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms	☐	☐	☐
	Total Number of Criteria			

Please check off any symptoms that have occurred in the past 12 months.

List of Substance Use Disorder(s) that Meet DSM-5 Criteria and Date of DSM-5 Diagnosis (specify severity level):

_____

_____

_____

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* The presence of at least 2 of these criteria indicates a substance use disorder.
** The severity of the substance use disorder is defined as:
- Mild: Presence of 2-3 criteria
- Moderate: Presence of 4-5 criteria
- Severe: Presence of 6 or more criteria

Placement Summary

Level of Care: Enter the ASAM Level of Care number that offers the most appropriate treatment setting given the client's current severity and functioning: _____

Level of Care Provided: If the most appropriate Level of Care is not utilized, then enter the next appropriate Level of Care and check off the reason for this discrepancy (below):

Reason for Discrepancy:

☐ Not Applicable ☐Service Not Available ☐Provider Judgment ☐Client Preference
☐ Transportation ☐Accessibility ☐Financial ☐Preferred to Wait
☐ Language/ Cultural Considerations ☐Environment ☐Mental Health
☐ Physical Health ☐ Other: _____

Briefly Explain Discrepancy: _____
_____

Designated Treatment Location and Provider Name: _____
_____

_____

Therapist Name Signature Date