Biopsychosocial History

Patient Name: _____DOB:_____Age:_____Today's Date:_____

SECTION 1: Reason for Referral/Presenting Problems

Please provide specific information regarding the origin and duration of the presenting problem:_____

_____

_____

_____

Current Symptom Checklist (rate intensity of symptoms currently present)

None	Symptom not present at this time
Mild	Symptom impacts quality of life, but no significant impairment of day-to-day functioning
Moderate	Symptom has significant impact on quality of life and/or day-to-day functioning
Severe	Symptom has profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative/disconnected	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	confusion	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psycho/motor issues	[ ]	[ ]	[ ]	[ ]	thought problems	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	other 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 perp.	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perp.	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perp.	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsession/compulsion	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) _____	[ ]	[ ]	[ ]	[ ]

SECTION 2: Current Safety Concerns/Assessment

Have you thought about hurting yourself or anyone else in the past few days or weeks? Yes No
If so, please explain: who were you thinking of hurting? _____
Did you make a plan? Yes No
If so, please explain:_____

Have you thought about hurting yourself or someone else prior to the past few days or weeks? Yes No
Did you make a plan? Yes No
If so, please explain:_____

Have you ever actually tried to hurt yourself or someone else? Yes No
If so, please explain:_____

Do you ever experience (see, hear, smell, taste) things that others cannot or do not experience? Yes No
If so, please explain:_____

Within the past couple weeks have you used any alcohol, drugs, or medications (that were not prescribed by a doctor)? Yes No
If so, what did you use? How much? And How often?_____

Have you been arrested, or in trouble with the law, for any reason? Yes No
If so, why and when were you arrested or in trouble with the law?_____
If so, do you have current legal proceedings in progress? Yes No
If so, please explain:_____

Did the court or your attorney advise that you come to our facility? Yes No
If so, who is your attorney or the judge that advised you? _____

Do you currently own any weapons? Yes No
If so, what type of weapons do you own _____
Where are the weapons currently stored?_____

Are you licensed to carry a firearm? Yes No
Do you carry any weapons with you? _____

SECTION 3: Background Information

Emotional/Psychiatric History

[Y] [N] Prior outpatient psychotherapy?
If yes, on _____occasions. Longest treatment by _____ for ____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Type of Treatment	Beneficial?

[Y] [N] Has any family member had outpatient psychotherapy? If yes, who/why (list all):_____

[Y] [N] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?
If yes, on _____occasions. Longest treatment at _____ from ___/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[Y] [N] Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?
If yes, who/why (list all):_____

[Y] [N] Prior or current psychotropic medication usage? If yes:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

[Y] [N] Has any family member used psychotropic medications? If yes, who/what/why (list all):_____
_____

Family History

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 pt at that time_____
[ ] father deceased for ___ years
age of pt at that time _____

Describe parents:

	Father	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

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

For adults, age of emancipation from home: _____ Circumstances:_____

For minors, current grade & school: _____

Special education or difficulties in school: _____

Special circumstances in childhood:_____

Immediate Family Information

Marital status:
[ ] single, never married
[ ] engaged ____ months
[ ] married for ____ years
[ ] divorced for ___ years
[ ] separated for ____ years

patient:
[ ] 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 w/relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient

List immediate family <u>not</u> living in same household as

Frequency of visitation of above: _____

Describe any past or current significant issues in ADULT <u>intimate</u> relationships: _____

_____

_____

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

_____

_____

_____

Academic Information

What is the highest grade you have completed in school? _____
Did you ever attend college? Yes No For how long? _____
If so, did you graduate? Yes No When? _____ Degree Received_____

Psychological Testing/Assessment Information

Have you ever had any type of psychological testing or assessment? Yes No
If so, when: _____ What was the purpose of the testing?_____
What type of tests did you take? _____
What were the findings from those tests? _____
What psychologist completed those tests? Name_____

Medical History (check all that apply for patient)

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

_____

List name of primary care physician:
Name _____ Phone _____

List name of psychiatrist: (if any):
Name _____ Phone _____

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

_____

_____

_____

List any known allergies:_____

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

[ ] tuberculosis	[ ] heart disease
[ ] birth defects	[ ] high blood pressure
[ ] emotional problems	[ ] alcoholism
[ ] behavior problems	[ ] drug abuse
[ ] thyroid problems	[ ] diabetes
[ ] cancer	[ ] Alzheimer's disease/dementia
[ ] mental retardation	[ ] stroke

[ ] other chronic or serious health problems:_____

_____

Describe any serious hospitalization or accidents:
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____

Substance Abuse History (check all that apply for patient)

Family alcohol/drug abuse history:
[ ] father
[ ] mother
[ ] stepparent/live-in
[ ] uncle(s)/aunt(s)
[ ] grandparent(s)
[ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status (patient):
[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Treatment history:

[ ] outpatient (age[s]_____
[ ] inpatient (age[s]_____
[ ] 12-step program (age[s]_____
[ ] stopped on own (age[s]_____
[ ] other (age[s]_____
Describe: _____

Substances used by patient:

Current or Past Use ( ) None or Identify Specifics Below (complete all that apply)	First use age	Last use age	(Yes/No)	Frequency	Amount
[ ] alcohol					
[ ] amphetamines/speed					
[ ] barbiturates/downers					
[ ] caffeine					
[ ] cocaine					
[ ] crack cocaine					
[ ] hallucinogens (e.g., LSD)					
[ ] inhalants (e.g., glue, gas)					
[ ] marijuana or hashish					
[ ] nicotine/cigarettes					
[ ] PCP					
[ ] prescription_____					
[ ] other_____					

Consequences of substance abuse (check all that apply): ( ) None or Identify:

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] unable to control amount [ ] relationship conflicts
[ ] other _____

Please describe any significant details regarding your medical and/or substance use/treatment history that you feel is relevant to your treatment:
_____
_____
_____

Socio-Economic Information (check all that apply for patient)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous
[ ] living companions are dysfunctional

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-abuse-based friends
[ ] no friends
[ ] distant from family of origin

Sexual history:
[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience _____
[ ] age first pregnancy/fatherhood
[ ] history of promiscuity age _____ to ___
[ ] history of unsafe sex @ age_____
Additional information: _____

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

Military Service
[ ] never in military
[ ] served in military - no incident
[ ] served in military - **with** incident

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison ___# of time(s)
total time served:_____
Describe last legal difficulty:_____

Financial situation:
[ ] no current financial problems
[ ] Large indebtedness
[ ] poverty or below income
[ ] impulsive spending
[ ] relationship conflicts over finances

Cultural/spiritual/recreational history:
cultural identity (e.g., ethnicity, religion): _____
currently active in community/rec activities? [Y] [N]
formerly active in community/rec activities? [Y] [N]
currently engage in hobbies? [Y] [N]
currently participate in spiritual activities? [Y] [N]
if answered "yes" to any of above, describe _____
_____
_____
_____
_____
_____
_____

SECTION 5: Patient Goals for Treatment

Briefly identify what you would like to see changed or improved by coming to LightHorse Healthcare Inc.:

1. _____
2. _____
3. _____

What else would be helpful if we knew about you?_____

_____

_____

This concludes the portion that is to be completed by the patient and/or parent/guardian, thank you!

SECTION 6: (To be filled out by clinician)

Mental Status Exam

Appearance	OK	Slight	Moderate	Severe	Comments/as evidenced by:
Unkempt, disheveled	(____)	(____)	(____)	(____)	_____
Clothing, dirty, atypical	(____)	(____)	(____)	(____)	_____
Odd phys. characteristics	(____)	(____)	(____)	(____)	_____
Body odor	(____)	(____)	(____)	(____)	_____
Appears unhealthy	(____)	(____)	(____)	(____)	_____
Posture	OK	Slight	Moderate	Severe	
Slumped	(____)	(____)	(____)	(____)	_____
Rigid, tense	(____)	(____)	(____)	(____)	_____
Body Movements	OK	Slight	Moderate	Severe	
Accelerated, quick	(____)	(____)	(____)	(____)	_____
Decreased, slowed	(____)	(____)	(____)	(____)	_____
Restlessness, fidgety	(____)	(____)	(____)	(____)	_____
Atypical, unusual	(____)	(____)	(____)	(____)	_____
Speech	OK	Slight	Moderate	Severe	
Rapid	(____)	(____)	(____)	(____)	_____
Slow	(____)	(____)	(____)	(____)	_____
Loud	(____)	(____)	(____)	(____)	_____
Soft	(____)	(____)	(____)	(____)	_____
Mute	(____)	(____)	(____)	(____)	_____
Atypical (e.g., slurring)	(____)	(____)	(____)	(____)	_____
Attitude	OK	Slight	Moderate	Severe	
Domineering, controlling	(____)	(____)	(____)	(____)	_____
Submissive, dependent	(____)	(____)	(____)	(____)	_____
Hostile, challenging	(____)	(____)	(____)	(____)	_____
Guarded, suspicious	(____)	(____)	(____)	(____)	_____
Uncooperative	(____)	(____)	(____)	(____)	_____
Affect	OK	Slight	Moderate	Severe	
Inappropriate to thought	(____)	(____)	(____)	(____)	_____
Increased lability	(____)	(____)	(____)	(____)	_____
Blunted, dull, flat	(____)	(____)	(____)	(____)	_____
Euphoria, elation	(____)	(____)	(____)	(____)	_____
Anger, hostility	(____)	(____)	(____)	(____)	_____
Depression, sadness	(____)	(____)	(____)	(____)	_____
Anxiety	(____)	(____)	(____)	(____)	_____
Irritability	(____)	(____)	(____)	(____)	_____
Perception	OK	Slight	Moderate	Severe	
Illusions	(____)	(____)	(____)	(____)	_____
Auditory/Visual hallucinations	(____)	(____)	(____)	(____)	_____
Other hallucinations	(____)	(____)	(____)	(____)	_____
Cognitive	OK	Slight	Moderate	Severe	
Alertness	(____)	(____)	(____)	(____)	_____
Attn. span, distractibility	(____)	(____)	(____)	(____)	_____
Short-term memory	(____)	(____)	(____)	(____)	_____
Long-term memory	(____)	(____)	(____)	(____)	_____
Judgment	OK	Slight	Moderate	Severe	
Decision making	(____)	(____)	(____)	(____)	_____
Impulsivity	(____)	(____)	(____)	(____)	_____
Thought Content	OK	Slight	Moderate	Severe	
Obsessions/compulsions	(____)	(____)	(____)	(____)	_____
Phobic	(____)	(____)	(____)	(____)	_____
Depersonalization	(____)	(____)	(____)	(____)	_____
Suicidal ideation	(____)	(____)	(____)	(____)	_____
Homicidal ideation	(____)	(____)	(____)	(____)	_____
Delusions	(____)	(____)	(____)	(____)	_____

Estimated level of intelligence:_____

Orientation: ____ Time ___ Place ____ Person ___ Situation

Able to hold normal conversation? ___Yes _____ No

Eye contact:_____

Level of insight & Motivation:

_____Complete denial _____ Slight awareness _____ Motivated for Change

_____Blames others _____ Blames self _____ Lacks Motivation for Change

_____Intellectual insight, but few changes likely _____Emotional insight, understanding, change can occur

Diagnostic Impression

Axis I: _____

_____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ GAF (within last year): _____

Initial Treatment Plan	**Target Date**
1. _____	_____
2. _____	_____
3. _____	_____

Provider Name & Credentials: _____

_____ _____

Provider Signature Date