

SHEPHERD RECOVERY AND COUNSELING SERVICES INC.

BIO-PSYCHOSOCIAL ASSESSMENT

To be completed within 2 weeks from the intake appointment.

All areas must be complete- no blanks.

DATE _____

FILE # _____

I. INTAKE INFORMATION

1. Client's name: _____

2. MEDICAID# _____

3. Home Address _____

Street

City

State

Zip

4. Telephone: Home _____ Other _____

5. Date of Birth _____

6. Age _____

7. S.S. # _____

8. Race/Ethnicity _____

9. Gender _____

10. Marital Status _____

11. Emergency Contact: _____

12. Relationship: _____ 13. Emergency Phone _____

14. DHS/OJA Custody? Yes _____ No _____

15. Employment Full time _____ Part time _____ Unemp. _____ Not in work force _____

16. Occupational code Professional/Technical _____ Manager/Administrative _____

Skilled Worker _____ Unskilled Worker _____ Farmer _____ None _____

17. Referral Source & Number _____

18. Presenting Problem _____

19. History of Presenting Problem _____

SHEPHERD RECOVERY AND COUNSELING SERVICES INC.

20. Previous Treatment History and/or Diagnostic History (Include diagnoses, treatment information and dates):

Mental Health _____

Substance Abuse _____

Domestic Violence _____

II. ASSESSMENT/INTERPRETATIVE SUMMARY - CURRENT

What assets does client have that will help him/her succeed in treatment? _____

What are the possible barriers/roadblocks that may hinder client's progress in treatment?

Type of treatment services needed: Individual/Interactive Family
 Rehabilitation/Life Skills Case Management Other _____

Frequency of Services Desired: Once weekly Twice weekly Other _____

Preferred Location of Services: Home School Other _____

List any specialized skills, therapeutic knowledge, and/or tools to be provided in order to enhance treatment outcome: _____

Are there any referrals to and/or collaboration with another agency? Yes ___ No ___

If yes, list name and telephone number _____

Are there any co-occurring disabilities/disorders that will affect treatment? Yes ___ No ___

If yes, what are they? _____

If yes, how will they be addressed in treatment? _____

Are there any needs for assistive technology? Yes ___ No ___

If yes, how will they be addressed in treatment? _____

Other pertinent information: _____

III. HEALTH HISTORY/CURRENT BIOMEDICAL CONDITIONS

1. Any current medical/health problems? Yes _____ No _____

2. If yes—what is the diagnosis/problem(s)? _____

3. If applicable - What treatments are you receiving? _____

4. Do you have an advanced directive? Yes _____ No _____
If so, how will it impact your treatment? _____

5. Any disabilities that would effect your treatment? Yes _____ No _____
If yes, please describe: _____

6. Any allergies to medication? Yes ___ No ___ List _____

7. Personal physician _____

8. Are you currently taking prescribed or over-the-counter medication? Yes ___ No ___
If yes, list medications below:

Medication	Physician	Strength/Dosage	Date Initiated

9. How have you adjusted to treatment/medication? _____

10. What present or past mediations were effective? Not effective? _____

IV. HISTORY OF VIOLENT BEHAVIOR/SUICIDAL TENDENCIES

1. Do you have a history of violent behavior? Yes _____ No _____
If yes, describe and include dates _____

2. Have you ever attempted suicide? Yes _____ No _____

If yes, describe and include dates _____

3. Do you currently have thoughts of hurting yourself or others? Yes _____ No _____

If yes, do you have a plan? Yes _____ No _____ N/A _____

If yes, what is it? _____

4. Any risk taking behaviors? Yes _____ No _____

If yes, please describe: _____

DOMESTIC VIOLENCE/ SEXUAL ASSAULT

1. Have you ever been a victim of emotional abuse and/or neglect?

Yes _____ No _____ If yes, describe: _____

2. Have you ever been a victim of domestic violence and/or other physical abuse?

Yes _____ No _____ If yes, describe: _____

3. Have you ever been a victim of sexual assault /abuse? Yes _____ No _____

If yes, describe: _____

Who was the perpetrator? _____

Any resolve? Please explain: _____

4. Have you ever received counseling for sexual assault /abuse? Yes _____ No _____

If yes, describe: _____

How recent or how long ago? _____

Do you feel this has helped you Yes _____ No _____

SHEPHERD RECOVERY AND COUNSELING SERVICES INC.

V. FAMILY/MARITAL, SOCIAL HISTORY, LIVING SITUATION

1. Family Member/Name	Age	City/State	Current Relationship
Father			
Mother			
Sisters			
Brothers			
Spouse			
Children			

2. With whom do you currently live? _____ Number in Home _____

3. Current Living Environment: ___ House ___ Apt ___ Duplex ___ Other: _____

4. Who have you lived with in the past? _____

5. Any significant childhood losses? Include divorce, death, and estrangement. _____

Age of loss (es) _____

6. Any history of alcohol/drug abuse or mental illness in family of origin?

Yes _____ No _____

If yes, list family member(s) _____

7. Have any family members been treated for any of the above? Yes _____ No _____

If yes, list family member(s) _____

8. Significant Other relationships: list year and length of relationship or marriage, year of separation or divorce, number of children: _____

9. Does significant other drink or use drugs? Yes _____ No _____ N/A _____

VI. EDUCATIONAL HISTORY

1. Last year completed _____ Name of school _____
2. Which grades, if any, did you repeat? _____
3. What vocational school or college have you attended? _____
4. List specialized training, if any _____
5. List and describe any suspensions or expulsions _____

II. CULTURAL/RELIGIOUS ORIENTATION

1. What is your race or ethnicity? Caucasian _____ African/American _____ Asian _____
Hispanic _____ Native American _____ Other _____
2. How will your cultural practices affect treatment? _____

3. What is your religious background? Protestant _____ Jewish _____ Catholic _____
Other _____ None _____
4. Does client attend church on a regular basis? Yes _____ No _____
5. Spiritual beliefs and practice of same? _____
6. Are you a U.S. citizen? Yes _____ No _____
If no, how long have you been in the U.S.? _____

III. OCCUPATIONAL/MILITARY HISTORY (clients 16 years +) N/A _____

1. Employer _____ Job title _____
Employer's address _____
Employer's phone number _____ How long employed? _____
Other sources of income (i.e. SSI, disability, VA, retirement, child support, etc.):

Previous employment:

Employer	Dates	Title	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____

SHEPHERD RECOVERY AND COUNSELING SERVICES INC.

2. What kinds of work of are you qualified to perform? _____

3. Have you ever been in the military? Yes _____ No _____
If yes, what branch, dates of service, and type of discharge? _____

IV. SEXUAL HISTORY N/A _____

1. Have you ever had a sexually transmitted disease? Yes _____ No _____
If yes, detail what, when, etc. _____

2. Are you currently sexually active? Yes _____ No _____ If yes, what
form(s) of protection and/or birth control do you use? _____

3. Do you desire help obtaining services for infection screening? Yes _____ No _____
If yes, note counselor's report of action taken to assure the requested services: _____

4. Sexual orientation: _____

V. RECREATIONAL/LEISURE HISTORY

1. What do you currently like to do for recreation? _____

2. How have you spent your leisure time in the past? _____

VI. LEGAL HISTORY N/A _____

1. What is your current legal status? _____

2. List chronologically any past convictions:

Offense	Felony/Misdemeanor	Age	Sentence	Jail Time

VII. ECONOMIC RESOURCES (adult clients) N/A _____

1. Do you own a home? Yes ____ No ____ 2. Do you rent a home? Yes ____ No ____

3. Do you own a car? Yes _____ No _____

4. How do you currently support yourself and your family financially? _____

VIII. CURRENT SUPPORT SYSTEM

1. To whom do you currently look for support? _____

2. Do they support your entering treatment? _____

3. Are you experiencing severe isolation or withdrawal from social contact?
Yes ____ No ____ If yes, explain: _____

IX. CLIENT'S QUALITIES (client responses needed)

1. What are your strengths/abilities? (Assets, resources, natural positives) _____

2. What are your needs/liabilities? (Weaknesses, what do you need to recover) _____

3. What are your abilities/interests? (Skills, aptitudes, capabilities talents, competencies) _____

4. What are your preferences? (What will enhance treatment experience?) _____

5. What do you expect from this program in terms of service? _____

6. Therapist's expectations _____

SHEPHERD RECOVERY AND COUNSELING SERVICES INC.

XV. MULTIAXIAL DIAGNOSIS

AXIS I (code and condition): _____

AXIS II (code and condition): _____

AXIS III: _____

AXIS IV: _____

AXIS V (current): _____ AXIS V (past year): _____

Clinician Signature & Credentials

Date

BIOPSYCHOSOCIAL ADDENDUM
CHILDREN AND ADOLESCENTS

XVI. SCHOOL HISTORY

1. Are you currently enrolled in school? Yes _____ No _____
2. Present school attending/will attend _____ Grade level _____
3. Have you had to repeat a grade? Yes _____ No _____ If yes, what grade? _____
4. Have you ever been placed in special education classes or a resource room? Yes _____
No _____ If yes, explain: _____
5. Have you been diagnosed with a learning disability? Yes _____ No _____
6. Do you have difficulty reading? Yes _____ No _____
7. Do you have difficulty writing? Yes _____ No _____
8. How are your grades now? _____
9. Have you failed any classes in the past year? Yes _____ No _____
10. Has your school performance changed? Yes _____ No _____
If yes, explain: _____
11. Have you been suspended or expelled? Yes _____ No _____
If yes, explain: _____
12. How many days did you miss school, the last semester you attended? _____

X. DEVELOPMENTAL HISTORY

1. Any problems at birth? _____
2. Prenatal exposure to alcohol, tobacco, or other drugs? Yes _____ No _____
If so, explain: _____
Source of information: _____
3. Age first walked? _____
4. Age first talked? _____

SHEPHERD RECOVERY AND COUNSELING SERVICES INC.

5. Known developmental delays _____

6. Any hearing problems? Yes ___ No ___ Has this been tested? Yes ___ No ___

7. Any vision problems? Yes ___ No ___ Has this been tested? Yes ___ No ___

8. Do you have problems with speech? Yes _____ No _____

9. Have you had any speech therapy? Yes _____ No _____

XI. FAMILY HISTORY/PLACEMENTS

1. Current legal custody or legal guardianship (may not be the same as current physical custody): Mother _____ Father _____ Joint _____ DHS _____ Other _____

2. With whom have you lived, and at what ages? _____

3. Note psychological problems of parents and other caretakers (list who and what):

XII. IMMUNIZATIONS

1. Are immunizations currently up to date? Yes _____ No _____
Source of information _____

XIII. PEER INTERACTIONS

1. Who are your friends? _____

2. What do you like to do together? _____

3. Do any of them drink or use drugs? _____

4. Any problems with peers? _____

5. Comments _____

Therapist's signature/credentials

Date