B. Danielle
Counseling & Coaching

404.490.0081 | www.bdanielle.com
3754 Lavista Rd #200, Tucker, GA 30084

CONFIDENTIAL BIOPSYCHOSOCIAL ASSESSMENT
(FULL INTAKE)

DEMOGRAPHICS

NAME:_____

ADDRESS (FULL):

_____

_____

MAY WE MAIL YOU INFORMATION? Y / N

BIRTHDATE: _____ AGE: _____ GENDER: _____

MARITAL STATUS: □MARRIED □SINGLE □DIVORCED □SEPARATED □PARTNERED □CHILDREN

HOME PH#: _____ MAY WE CALL? Y / N
CELL PH#: _____ MAY WE CALL? Y / N
EMAIL: _____ MAY WE EMAIL? Y / N

EMERGENCY CONTACT: _____ PH #: _____

Insurance

Primary
Insured's Name: _____
SSN: _____-_____-_____
Relationship to Patient: _____
ID Number: _____
DOB: _____

Secondary
Insured's Name: _____
SSN: _____-_____-_____
Relationship to Patient: _____
ID Number: _____
DOB: _____

USING EMPLOYEE ASSISTANCE PROGRAM? **Y / N** IF YES, WHICH PROVIDER? _____

PSYCHOLOGICAL/ MENTAL HEALTH HISTORY

PREVIOUS THERAPY ? **Y / N**
DETAILS OF THERAPY: _____
_____

PREVIOUS HOSPITALIZATION? **Y / N**
DETAILS OF HOSPITALIZATION(S): _____
_____

PSYCHIATRIST NAME (IF APPLICABLE) _____
PSYCHIATRIST ADDRESS: _____
PSYCHIATRIST PHONE #: _____

PRESENT PSYCHOTROPIC MEDICATION (IF APPLICABLE)
_____
_____

PAST PSYCHOTROPIC MEDICATIONS (IF APPLICABLE)
_____
_____

PREVIOUS OR CURRENT MENTAL HEALTH DIAGNOSIS (IF APPLICABLE)
_____
_____

FAMILY HISTORY OF MENTAL HEALTH OR SUBSTANCE ABUSE ISSUES:
_____
_____
_____
_____

BIOLOGICAL/PHYSICAL

PRESENT AND/OR PAST MEDICAL CONDITIONS:

_____

_____

PAST MEDICAL COMPLICATIONS, SURGURIES, ACCIDENTS? (IF YES EXPLAIN)

_____

_____

HISTORY OF LEARNING DISABILITIES OR DEVELOPMENTAL DELAYS:

_____

_____

PRESENT PRIMARY CARE PHYSICIAN & DATE OF LAST PHYSICAL:

_____

_____

PRESENT MEDICATIONS (ex., prescription, herbal remedies, vitamins, or drugstore medications):_____

_____

ANY USE OF PRESCRIPTION DRUGS, STREET DRUGS/SUBSTANCES FOR RECREATIONAL USE? **Y/ N** IF YES, PLEASE DESCRIBE USE:

_____

_____

IF SO, DO YOU WANT TO CHANGE THE USE OF ANY SUBSTANCES? **Y / N**

FAMILY HISTORY

CURRENT MARITAL STATUS OF MY PARENTS: □MARRIED □SINGLE PARENT □DIVORCED
□SEPARATED □PARTNERED □NEVER MARRIED □WIDOWED □BOTH DECEASED

MY CURRENT RELATIONSHIP WITH MY FATHER IS:_____

MY CURRENT RELATIONSHIP WITH MY MOTHER IS:_____

I HAVE SIBLINGS: □YES

I HAVE/HAD STEP-PARENTS: □NO □YES
IF YES, MY CURRENT RELATIONSHIP WITH THEM IS: □CLOSE □DISTANT □NO CONTACT

MY PRIMARY CAREGIVER WAS: □SELF □SIBLING(S) □MOTHER □FATHER □OTHER

MY CHILDHOOD HOME WAS: □STABLE □UNSTABLE □OTHER _____

THERE ARE SIGNIFICANT CONCERNS FROM MY CHILDHOOD THAT ARE CURRENTLY IMPACTING ME: **Y / N** IF YES, PLEASE EXPLAIN:

_____

_____

WHO DO YOU CURRENTLY LIVE WITH?

_____

_____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse	☐ Neglect	☐ Lived in a foster home
☐ Sexual abuse	☐ Violence in the home	☐ Multiple family moves
☐ Physical abuse	☐ Crime victim	☐ Homelessness
☐ Parent substance abuse	☐ Parent illness	☐ Loss of a loved one
☐ Teen pregnancy	☐ Placed a child for adoption	☐ Financial problems

EDUCATION

ARE YOU IN SCHOOL PRESENTLY? **Y / N**
HIGHEST LEVEL OF EDUCATION COMPLETED? _____
DO YOUU HAVE SCHOOL RELATED STRESS? **Y / N**

EMPLOYMENT

ARE YOU CURRENTLY EMPLOYED? **Y / N** IF SO, WHERE & POSITION:
_____

DO YOU HAVE JOB RELATED STRESS? **Y / N** IF SO, PLEASE DESRIBE:
_____

LEGAL HISTORY

DO YOU HAVE CURRENT OR PAST LEGAL HISTORY: **Y / N**
IF YES, PLEASE EXPLAIN: _____
_____

SOCIAL/CULTURAL/RELIGIOUS BACKGROUND

- I AM APART OF A SPECIFIC CULTURE OR ETHNICITY: **Y / N**
- I ENGAGE IN SPECIFIC RELIGIOUS OR CULTURAL PRACTICES: **Y / N**
- I AM A SPIRITUAL PERSON: **Y / N**
- I AM CONNECTED WITH A RELIGION OR SPIRITUAL GROUP: **Y / N**
- I HAVE SEXUALITY OR GENDER CONSIDERATIONS: **Y / N**
- I HAVE A SUPPORT SYSTEM: **Y / N**

WHAT ARE SOME OF YOUR STRENGTHS, GIFTS AND TALENTS?
_____
_____

WHAT ARE SOME OF YOUR HOBBIES, SPECIAL INTERESTS, ETC?
_____
_____

PRESENTING CONCERNS:

PLEASE DESCRIBE THE PROBLEMS THAT BROUGHT YOU IN TODAY:

_____

_____

_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other:_____

- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations

- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

RISK ASSESSMENT:

- IN THE PAST 30 DAYS, HAVE YOU FELT LIKE YOU WANTED TO KILL YOURSELF OR KILL SOMEONE ELSE? **Y / N**
- IN THE PAST 30 DAYS, HAVE YOU MADE ATTEMPTS TO KILL YOURSELF OR SOMEONE ELSE? **Y / N**
- IF YES TO ANY OF THE ABOVE, DO YOU HAVE A PLAN TO KILL YOURSELF OR KILL SOMEONE ELSE?
- DO YOU HAVE ACCESS TO FOLLOW THROUGH WITH YOUR PLAN? **Y / N**
- HAVE YOU EVER IN THE PAST 12 MONTHS THOUGHT ABOUT KILLING YOURSELF OR SOMEONE ELSE? **Y / N**
- HAVE YOU EVER IN THE PAST 12 MONTHS ATTEMPTED TO KILL YOURSELF OR SOMEONE ELSE? **Y / N**