

CLINTON COUNSELING CENTER – ADULT BIOPSYCHOSOCIAL ASSESSMENT

DEMOGRAPHICS

Legal Name:			
Age:	Date of Birth:	Social Security #:	
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other:			
Current Address: Street: City/State: Zip:		Current Phone: Home: Cell:	
Emergency Contact:		Phone:	
<input type="checkbox"/> Guardian <input type="checkbox"/> Representative payee <input type="checkbox"/> Personal representative Name: _____ Phone: _____			
Insurance Information: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> MiChild <input type="checkbox"/> Value Options <input type="checkbox"/> Cigna <input type="checkbox"/> United Behavioral Healthcare <input type="checkbox"/> Aetna <input type="checkbox"/> Adult Benefit Waiver <input type="checkbox"/> Medicaid Spend down <input type="checkbox"/> Other _____ <input type="checkbox"/> No Insurance Benefits – current household income: _____			

SUBSTANCE USE HISTORY:

Consequences as a result of Drug/Alcohol Use (select all that apply)

<input type="checkbox"/> Hangovers	<input type="checkbox"/> Seizures	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Drinking & Driving
<input type="checkbox"/> Overdoses	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lost Job	<input type="checkbox"/> Stealing for drugs
<input type="checkbox"/> Binges	<input type="checkbox"/> GI Bleeding	<input type="checkbox"/> Left School	<input type="checkbox"/> Arrest
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Increased tolerance	<input type="checkbox"/> Relationship Losses	<input type="checkbox"/> Jail
<input type="checkbox"/> DTs/Shakes	(need more to get high)	<input type="checkbox"/> Traded sex for drugs	<input type="checkbox"/> Other:

Risk Taking/Impulsive Behaviors (current or past) – select all that apply

<input type="checkbox"/> Gambling	<input type="checkbox"/> Gang involvement	<input type="checkbox"/> Selling drugs	<input type="checkbox"/> Reckless driving
<input type="checkbox"/> Unprotected sex	<input type="checkbox"/> Shoplifting	<input type="checkbox"/> Carry/using weapons	<input type="checkbox"/> Other _____

Client's thoughts about making changes to substance use:

<input type="checkbox"/> Not ready to quit	<input type="checkbox"/> Making plans to quit	<input type="checkbox"/> Quit and need help to prevent a relapse
<input type="checkbox"/> Thinking about quitting	<input type="checkbox"/> Already started making changes	

History of Substance Abuse Treatment: No previous treatment

Name of Treatment Program	Type of Treatment	Date of Treatment	Status
	<input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:
	<input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:
	<input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:
	<input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:
	<input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:

Clinical Impression: (Staff use only):

PSYCHOLOGICAL/EMOTIONAL:

Check all current symptoms:

<input type="checkbox"/> Depressed mood	<input type="checkbox"/> No motivation	<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Frequent crying spells	<input type="checkbox"/> No interest in activities	<input type="checkbox"/> Manic episode	<input type="checkbox"/> Paranoia
<input type="checkbox"/> No energy	<input type="checkbox"/> Changes in weight	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Thoughts of death
<input type="checkbox"/> Irritable often	<input type="checkbox"/> Feeling worthless	<input type="checkbox"/> Constant worry	<input type="checkbox"/> Obsessions
<input type="checkbox"/> Problems concentrating	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hyperactivity

History of Suicide Attempts No Yes When: _____ How: _____

History of Hurting Others No Yes When: _____ How: _____

Past/Current Mental Health Diagnosis: _____

Current Mental Health Medications: _____

Doctor prescribing medications? Name: _____ Phone: _____

Address: _____

Past Mental Health Medications: _____

Family history of mental health disorders:

Family Member	Diagnosis

History of Mental Health Treatment: No previous treatment

Name of Treatment Program	Type of Treatment	Date of Treatment	Status
	<input type="checkbox"/> Hospital <input type="checkbox"/> Partial Day <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:
	<input type="checkbox"/> Hospital <input type="checkbox"/> Partial Day <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:
	<input type="checkbox"/> Hospital <input type="checkbox"/> Partial Day <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:
	<input type="checkbox"/> Hospital <input type="checkbox"/> Partial Day <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:
	<input type="checkbox"/> Hospital <input type="checkbox"/> Partial Day <input type="checkbox"/> Outpatient		<input type="checkbox"/> Completed <input type="checkbox"/> Dropped Out <input type="checkbox"/> Other:

Clinical Impression: (Staff use only):

MEDICAL:

Medical Condition(s):	Medication(s)	Dose

Allergic to any medications? No Yes What medication(s)? _____

Primary Care Physician's Name: <input type="checkbox"/> No primary care physician	Address:	Phone:
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Detoxification History: Substance(s): _____ Never detoxed
 Symptoms: DTs/Shakes Vomiting Diarrhea Seizures Achy Sleeplessness
 No appetite Anxiety Hallucinations Other: _____

Current Sleep: No sleep problems Can't fall asleep Waking often in the night
 Sleep more than 9 hours per night Sleep less than 6 hours per night

Current Exercise: None Exercise 1-3x/month Exercise 1-3x/week Exercise daily

Current Diet: Healthy eating Overeating Eating mostly junk food
 Bulimia (eating too much and vomiting) Anorexia (not eating enough)

Current appetite: Good Fair Poor

Clinical Impressions: (Staff use only):

FAMILY OF ORIGIN: (What happened while growing up – check all that apply)

Who raised client? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Other: _____
Substance use in the family? <input type="checkbox"/> No <input type="checkbox"/> Yes Who? _____
Client was disciplined by: <input type="checkbox"/> Not disciplined <input type="checkbox"/> Spanked/hit <input type="checkbox"/> Yelled at <input type="checkbox"/> Time out/grounding
Verbal Abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes Age of abuse _____ By Whom? _____
Physical Abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes Age of abuse _____ By Whom? _____
Neglect? <input type="checkbox"/> No <input type="checkbox"/> Yes Age of abuse _____ By Whom? _____
Impression of upbringing: <input type="checkbox"/> Healthy <input type="checkbox"/> Fair <input type="checkbox"/> Dysfunctional

Clinical Impressions: (Staff use only):

ETHNIC/CULTURAL/SPIRITUAL BACKGROUND:

What cultural group do you identify with the most (check all that apply):

<input type="checkbox"/> Caucasian (White)	<input type="checkbox"/> African American (Black)	<input type="checkbox"/> Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Native American
<input type="checkbox"/> Other: _____		

What religious group do you identify with the most (check all that apply):

<input type="checkbox"/> None	<input type="checkbox"/> Baptist	<input type="checkbox"/> Lutheran	<input type="checkbox"/> Protestant	<input type="checkbox"/> Jewish
<input type="checkbox"/> Catholic	<input type="checkbox"/> Muslim	<input type="checkbox"/> Non-denominational	<input type="checkbox"/> Jehovah Witness	<input type="checkbox"/> Other: _____

What are your spiritual beliefs?

<input type="checkbox"/> Believe in Higher Power	<input type="checkbox"/> Uses prayer	<input type="checkbox"/> Seeking connection with others
<input type="checkbox"/> Seeking harmony	<input type="checkbox"/> Believe in Karma	<input type="checkbox"/> Want to strengthen spirituality

Clinical Impressions: (Staff use only):

SEXUALITY:

Check all that apply:

Sexual Orientation:	<input type="checkbox"/> Heterosexual (like opposite sex)	<input type="checkbox"/> Homosexual/Gay/Lesbian
	<input type="checkbox"/> Bisexual (like both sexes)	<input type="checkbox"/> Transgender
	<input type="checkbox"/> Comfortable with sexual orientation	<input type="checkbox"/> Concerns with sexual orientation
Sexual abuse:	<input type="checkbox"/> Have been sexually abused Age of abuse: _____ By whom: _____	
	<input type="checkbox"/> Have sexually abused others	
	<input type="checkbox"/> No history of sexual abuse	
	<input type="checkbox"/> Sexual abuse history is a current area of concern	

Clinical Impressions: (Staff use only):

CURRENT FAMILY RELATIONSHIPS:

Marital Status: Never Married Married Separated Divorced Widowed

Living with partner In relationship

Children: None

Name	Age	Gender	Client has custody?	Child lives with?	Additional information
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Has client ever had involvement with Child Protective Services? No Yes Year: _____

Check all that apply:

	Deceased	Regular contact	Infrequent/ No contact	Supports recovery	Does not understand recovery	Used substances with	Conflict in relationship
Spouse/Partner							
Mother							
Father							
Sibling: _____							
Sibling: _____							
Sibling: _____							
Child: _____							
Child: _____							

Identify family that would be willing to participate in treatment to assist client in recovery: _____

Clinical Impression: (Staff use only):
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CURRENT SOCIAL SUPPORTS:

Check all that apply:

<input type="checkbox"/> No current social support	<input type="checkbox"/> Isolating	<input type="checkbox"/> Have a current sponsor
<input type="checkbox"/> Friends that use substances	<input type="checkbox"/> Anxiety makes it hard to meet people	<input type="checkbox"/> Friends that support recovery

AA/NA Meetings (check all that apply):

<input type="checkbox"/> Never attended any meetings	<input type="checkbox"/> Don't like meetings	<input type="checkbox"/> Attend meetings 1-3x/month
<input type="checkbox"/> Attended meeting in the past	<input type="checkbox"/> Find meetings helpful	<input type="checkbox"/> Attend meetings 1-3x/week
<input type="checkbox"/> Currently attending meetings	<input type="checkbox"/> Need to go to meetings again	<input type="checkbox"/> Attend meetings daily

Clinical Impression: (Staff use only):

CURRENT LEISURE/RECREATION/TIME MANAGEMENT:

Check all that apply: Do not participate in any activities

Activity	Past activity	Present activity	Substance use involved with this activity
Time with friends			
Time with family			
Classes/School			
Work			
Hobby: _____			
Watch television/Play video games			
Clubs/Bars			
Casinos			
Participate in sports/exercise			
Other: _____			

Clinical Impression: (Staff use only):

EDUCATIONAL:

Check all that apply:

Education: <input type="checkbox"/> High School Graduate or GED <input type="checkbox"/> Less than 12 years of school: Last grade completed: _____ <input type="checkbox"/> College: # of years _____ <input type="checkbox"/> Vocational Schooling: # of years _____
Current Schooling: <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you need help with reading and/or writing? <input type="checkbox"/> No <input type="checkbox"/> Yes
Any learning disabilities or other educational or learning problems? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____
How do you learn the best? <input type="checkbox"/> Reading <input type="checkbox"/> Writing <input type="checkbox"/> Listening to information <input type="checkbox"/> Practicing

Clinical Impression: (Staff use only):

EMPLOYMENT/VOCATIONAL:

<input type="checkbox"/> EMPLOYED <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contractual/Side Jobs			
Employer: _____		Length of Employment: _____	
Job Description: _____			
Check all that apply: <input type="checkbox"/> Satisfied <input type="checkbox"/> Not satisfied <input type="checkbox"/> Conflict with supervisor <input type="checkbox"/> Conflict with coworkers <input type="checkbox"/> I have used substances at work <input type="checkbox"/> Others use substances at work <input type="checkbox"/> Employment will help with recovery <input type="checkbox"/> Employment could hurt recovery Explanation: _____			
<input type="checkbox"/> UNEMPLOYED Last employer: _____ Reason for leaving: _____			
<input type="checkbox"/> Currently looking for work	<input type="checkbox"/> Disabled	<input type="checkbox"/> Need job skills training	<input type="checkbox"/> Currently in school
<input type="checkbox"/> Never been employed	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Unstable work history	<input type="checkbox"/> History of Military service
<input type="checkbox"/> Not looking for work due to: _____			

Clinical Impression: (Staff use only):
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LEGAL:

Current Legal Status: None Probation Parole Awaiting Sentencing Awaiting Trial

History of Legal Charges:

Charge (most recent first)	Year Arrested for Charge	Outcome

Clinical Impression: (Staff use only):
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FINANCIAL STATUS:

Check all that apply:

Finances are: <input type="checkbox"/> Stable <input type="checkbox"/> Struggling to pay bills <input type="checkbox"/> Need assistance with basic needs
Need help with: <input type="checkbox"/> Nothing <input type="checkbox"/> Rent/Mortgage <input type="checkbox"/> Food <input type="checkbox"/> Utilities (electric, gas, water) <input type="checkbox"/> Healthcare <input type="checkbox"/> Transportation <input type="checkbox"/> Other: _____
Money management: <input type="checkbox"/> Able to budget <input type="checkbox"/> Gambling problems <input type="checkbox"/> Compulsive spending <input type="checkbox"/> Hoarding money

Clinical Impression: (Staff use only):
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FUNCTIONAL ASSESSMENT:

Client able to care for self? <input type="checkbox"/> Yes <input type="checkbox"/> No – Explain:
Living Situation: <input type="checkbox"/> Housing adequate <input type="checkbox"/> Housing overcrowded <input type="checkbox"/> Housing dangerous <input type="checkbox"/> Doubled up – living in someone else’s house <input type="checkbox"/> Transitional or ¾ housing <input type="checkbox"/> Homeless <input type="checkbox"/> Temporary Shelter <input type="checkbox"/> At risk of homelessness
Assistive/Adaptive Needs: <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> Braille <input type="checkbox"/> Cane <input type="checkbox"/> None <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Reads lips <input type="checkbox"/> Needs sign language <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Wheelchair <input type="checkbox"/> Translated verbal information – Language: _____ <input type="checkbox"/> Translated written information – Language: _____

SNAP (Strengths, Needs, Abilities and Preferences)

Strengths: <input type="checkbox"/> Family support <input type="checkbox"/> Desire for help <input type="checkbox"/> Social support <input type="checkbox"/> Financial stability <input type="checkbox"/> Spiritual <input type="checkbox"/> Resilient <input type="checkbox"/> Stable relationship <input type="checkbox"/> Stable housing <input type="checkbox"/> Other: _____
Needs: <input type="checkbox"/> Coping skills <input type="checkbox"/> Relapse prevention skills <input type="checkbox"/> Support for recovery <input type="checkbox"/> Medications <input type="checkbox"/> Transportation <input type="checkbox"/> Financial help <input type="checkbox"/> Other: _____
Abilities: <input type="checkbox"/> Insightful <input type="checkbox"/> Good communication skills <input type="checkbox"/> Good writing skills <input type="checkbox"/> Other: _____
Preferences: <input type="checkbox"/> Appointment times – Needs: _____ <input type="checkbox"/> Therapist in Recovery <input type="checkbox"/> Male Therapist <input type="checkbox"/> Female Therapist <input type="checkbox"/> Group therapy <input type="checkbox"/> Individual therapy