CLINTON COUNSELING CENTER – ADULT BIOPSYCHOSOCIAL ASSESSMENT

DEMOGRAPHICS

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

SUBSTANCE USE HISTORY:

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

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

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

□ Gambling	□ Gang involvement	□ Selling drugs	□ Reckless driving
□ Unprotected sex	□ Shoplifting	□ Carry/using weapons	□ Other _____

Client's thoughts about making changes to substance use:

□ Not ready to quit	□ Making plans to quit	□ Quit and need help to prevent a relapse
□ Thinking about quitting	□ Already started making changes	

History of Substance Abuse Treatment: □ No previous treatment

Name of Treatment Program	Type of Treatment	Date of Treatment	Status
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:

Clinical Impression: (Staff use only):

PSYCHOLOGICAL/EMOTIONAL:

Check all current symptoms:

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

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

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

Current suicidal ideation:_____

History of trauma: Experienced_____ Witnessed:_____

Abuse:_____ Neglect:_____ Violence:_____ Sexual Assault:_____

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
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:

Clinical Impression: (Staff use only):

MEDICAL:

Medical Condition(s):	Medication(s)	Dose

Allergic to any medications? □ No □ Yes What medication(s)? _____
Are you Pregnant? □ No □ Yes □ Not Applicable

Primary Care Physician's Name: □ No primary care physician	Address:	Phone:

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

In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?
□ Daily or Almost Daily □ Weekly □ Monthly □ Less than monthly □ Never

Clinical Impressions: (Staff use only):

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

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

Clinical Impressions: (Staff use only):

ETHINIC/CULTURAL/SPIRITUAL BACKGROUND:

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

□ Caucasian (White)	□ African American (Black)	□ Latino
□ Asian	□ Hispanic	□ Native American
□ Other: _____		

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

□ None	□ Baptist	□ Lutheran	□ Protestant	□ Jewish
□ Catholic	□ Muslim	□ Christian	□ Jehovah Witness	□ African traditional
□Buddhism	□Hinduism	□ Non-denominational	□Nonreligious(Secular/Agnostic/Atheist)	□ Other

What are your spiritual beliefs?

□ Believe in Higher Power	□ Uses prayer	□ Seeking connection with others
□ Seeking harmony	□ Believe in Karma	□ Want to strengthen spirituality

Clinical Impressions: (Staff use only):

SEXUALITY AND GENDER ROLE:

Check all that apply:

Gender:

□ Female □ Male □ Nonbinary □ Transgender □ Gender Questioning □ Gender Fluid

□ Intersex □ Agender □ Bigender □ Maverique □ Novigender

Sexual Orientation: (Check all that apply)

□ Heterosexual
□ Homosexual/Gay/Lesbian
□ Bisexual
□ Polysexual
□ Pansexual
□ Queer
□ Questioning
□ Asexual
□ Comfortable with sexual orientation
□ Concerns with sexual orientation

Sexual abuse:

□ No history of sexual abuse
□ Have been sexually abused Age of abuse:_____ By whom: _____
□ Have sexually abused others
□ Have been human trafficked
□ 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
		□ M □ F	□ Yes □ No		
		□ M □ F	□ Yes □ No		
		□ M □ F	□ Yes □ No		
		□ M □ F	□ Yes □ 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):

CURRENT SOCIAL SUPPORTS:

Check all that apply:

□ No current social support	□ Isolating	□ Have a current sponsor
□ Friends that use substances	□ Anxiety makes it hard to meet people	□ Friends that support recovery

AA/NA Meetings (check all that apply):

□ Never attended any meetings	□ Don't like meetings	□ Attend meetings 1-3x/month
□ Attended meeting in the past	□ Find meetings helpful	□ Attend meetings 1-3x/week
□ Currently attending meetings	□ Need to go to meetings again	□ 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: □ High School Graduate or GED □ Less than 12 years of school: Last grade completed: _____
□ College: # of years _____ □ Vocational Schooling: # of years _____

Current Schooling: □ No □ Yes

Do you need help with reading and/or writing? □ No □ Yes

Any learning disabilities or other educational or learning problems? □ No □ Yes: _____

How do you learn the best? □ Reading □ Writing □ Listening to information □ Practicing

Clinical Impression: (Staff use only):

EMPLOYMENT/VOCATIONAL:

□ EMPLOYED □ Full-time □ Part-time □ Contractual/Side Jobs
Employer: _____ Length of Employment: _____
Job Description: _____
Check all that apply: □ Satisfied □ Not satisfied □ Conflict with supervisor □ Conflict with coworkers
□ I have used substances at work □ Others use substances at work
□ Employment will help with recovery □ Employment could hurt recovery
Explanation: _____

□ UNEMPLOYED Last employer: _____
Reason for leaving: _____
□ Currently looking for work □ Disabled □ Need job skills training □ Currently in school
□ Never been employed □ Homemaker □ Unstable work history □ History of Military service
□ Not looking for work due to: _____

VETERAN STATUS

I am a Veteran: □Yes □No
Branch
Years in service:
Era:
Family Military Service:
Enrolled in VA resources: □Yes □No

Clinical Impression: (Staff use only):

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):

FINANCIAL STATUS:

Check all that apply:

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

Clinical Impression: (Staff use only):

FUNCTIONAL ASSESSMENT:

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

SNAP (Strengths, Needs, Abilities and Preferences)

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

Signature of person completing form: _____
Date: _____

**************************************STAFF USE ONLY**************************************

CLINICAL SUMMARY:

_____ _____
Therapist Signature and Credentials Date

_____ _____
Director Signature Date