Biopsychosocial Assessment  Client ID_____

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Biopsychosocial Assessment (ADULT)

Name: _____ Date of Birth: _____
Address:_____
Telephone Number:_____
Cell: _____ Work? _____
Email: _____
Can you receive mail at this address? _____
Can we call you at home: _____ At work?_____ Email? _____
Can messages be left on your machine? At home?_____ At Work? _____
Do you have an advanced directive? _____ On file? __
Do you have a living will? _____ On file? __
Do you have a mental health surrogate? _____ On file? __
Who? _____

Marital status:
Married _____ Never married_____ Separated_____
Remarried_____ Divorced_____ Widowed _____

How many times have you been married? _____
_____
_____

Have you received services from this Agency before? _____
When? _____

Religion: _____ Culture: _____
Rate Importance 1 (not at all) – 5 (Extremely) ____

Do you own your home? _____

How many years of education did you complete? _____
Where did you go to school? _____

Military Experience? _____

Are you Currently Employed? _____
How many days have you missed in the past month due to medical problems?
_____

Biopsychosocial Assessment Client ID_____

Past Employment:

_____
_____
_____
_____

List those who live in the house with you?

_____
_____
_____

Were you raised by your biological parents?

_____
_____

Are they married? _____
Where do they live?_____

Do you have children? How many? Where are they?

_____
_____
_____
_____
_____
_____

Have you ever received mental health treatment before?

_____
_____
_____
_____

Do any of these apply?

Nightmares	Stomach Troubles
Mood shifts	Fatigue
Unable to relax	No Appetite
Cant keep a job	Excessive Eating
Concentration Difficulties	Trouble Sleeping
Memory Problems	Sleeping to much
Easily Distracted	Overspending
Can’t Make decisions	Excessive gambling

Fainting Spells	Crying easily
Arguments with relatives	Anger outbursts
Arguments with people	Shy with people
Can't make friends	Inferiority feelings
Sexual difficulties	Poor Home conditions
Feeling Nervous	Need to Count Things
Hear Voices	Feel Paranoid
Believe people are talking about you	Believe people can read your mind
Believe people are following you	

In the past month have you been bothered by:

An unexpected panic or anxiety attack (sudden fear for no reason) Yes _____ No _____

Persistent, senseless thoughts that you can't get out of your mind? Yes _____ No _____

Feeling very uncomfortable in situations involving people Yes _____ No _____

Persistently worrying about several different things Yes _____ No _____

Being afraid of not being able to get help or escape when on a bridge, in a tunnel in a crowded store Yes _____ No _____

Being afraid to do things in front of people Yes _____ No _____

Unexplained palpitations (heart racing) or shortness of breath for no apparent reason Yes _____ No _____

Being afraid of things not involving people (phobias) Yes _____ No _____

Being unable to travel alone Yes _____ No _____

Doing things over and over again? Yes _____ No _____

Biopsychosocial Assessment Client ID_____

Feeling nervous or tense much of the time Yes _____ No _____

2. Do you fell sad or depressed? Yes _____ No _____

3. Have you ever attempted suicide? Yes _____ No _____
How? _____
When?_____
Where? _____

How often do you think about death/ suicide? _____

Have you ever been hospitalized for suicidal ideations?

As a child, have you ever been physically punished in a way that would be considered abusive or left marks/bruises? _____

As an adult have you ever been in a relationship with a significant other where you have been physically touched during an argument?
_____
_____

Has anyone made you engage in sexual acts against your will?
_____
_____

Have you been a victim of a violent crime in the past two years?
_____
_____

In the past six months have you experienced:

Death of a close family member	School Failure
Marital separation	Terminal Illness of a loved one
Divorce	Legal Troubles
Break up of a romantic relationship	Financial Setback
Pregnancy	Relocation to a new city
Birth of a child	Change in residence
Miscarriage	Change in Job
Job Termination	Retirement
Change in Friends	Change in Physical Health
Medical Diagnosis	

Biopsychosocial Assessment Client ID_____

Do you find yourself concerned about your body shape or weight?

Have you ever been diagnosed with an eating disorder?

Have you received treatment?

Do you ever do the following things to control your weight?

Vomit	Laxatives
Vigorous Exercise	Fasting
Strict Diet	Diuretics

How often do you drink alcohol?

_____

	Weekly	Daily
Beer		
Wine		
Hard Liquor		

Has anyone ever felt that you should cut down on your drinking?

Has anyone suggested that you night have a drinking problem?

Have you ever drank first thing in the morning to get rid of your hangover?

Have you taken non prescription drugs?

Does your drug use interfere in your ability to perform your responsibilities?

Have you ever received drug treatment?

Last time used

	Pot
	Cocaine (crack)
	Heroin

	Oxycodone
	Xanex
	Estacy

Family History

Alcoholism	
Drug Use	
Mental Illness	
Depression	
Suicide Attempt	
Suicide	

Have you ever been arrested?

_____
_____
_____
_____

How would you judge your housing situation?

_____
_____

Is counseling court ordered?

_____
_____

Medical Problems:

_____
_____
_____

Medications:

_____
_____
_____
_____

Biopsychosocial Assessment Client ID_____

What brought you to therapy today?

_____
_____
_____

When did these symptoms start?

_____
_____
_____

What (if any) incident started the symptoms?

_____
_____
_____

What would you like to accomplish in counseling?

_____
_____
_____
_____

Clients Preferred Language: _____

Strengths/Hobbies:

_____
_____
_____

Mental Status:					
Appearance	Well Groomed	Disheveled	Bizarre	Inappropriate	Provocative
Attitude:	Cooperative	Guarded	Suspicious	Belligerent	Uncooperative
Motor Activity	Calm	Hyperactive	Agitated	Tremors Tics	Muscle Spasm
Impulse Control	Good	Impaired			
Intellect	Average	Above	Below		
Memory	Immediate	Recent	Remote		
Concentration	Intact	Impaired			
Attention	Intact	Impaired			
Behavior	Appropriate	Inappropriate			
Mood	Euthymic	Anxious	Euphoric	Depressed	Apathetic
Affect	Appropriate	Labile	Expansive	Blunted	Flat
Orientation	Fully Oriented	Impaired	Time	Place	Person
Speech	Normal	Delayed	Pressured	Incoherent	Perseverating
Insight	Intact	Impaired	Minimal	Moderate	Severe
Judgment	Intact	Impaired	Minimal	Moderate	Severe
Suicidal Ideation	Yes	No			
Homicidal Ideation	Yes	No			

Biopsychosocial Assessment Client ID_____

Comments:
_____
_____

Safety Plan_____ Involuntary Hospitalization _____Referral to Psychiatrist ____

Initial Diagnostic Impression:

Clinical: _____

_____

_____

Medical:

_____

_____

Stressors: ___Family ____School _____Work _____Health _____Legal
_____ Mild _____Moderate _____ Severe

Clinical Impression

_____
_____
_____
_____
_____
_____
_____

Clinician's Signature: _____

Date: _____

Initial Treatment Plan

Client's Name: _____

Diagnosis Code: _____

What I would like to accomplish in therapy? (Goals):

Goals should be individualized, strength-based, and appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the recipient

Goal 1. _____

_____

Goal 2. _____

_____

Goal 3. _____

_____

How am I going to accomplish these goals? (Objectives)

(*Measurable objectives with target completion dates that are identified for each goal)*

Objective 1.

_____

_____

Target completion date: _____

Objective 2.

_____

_____

Target completion date: _____

Objective 3.

_____

_____

Target completion date: _____

Services to be Provided:	Duration Per Week/Month
Psychotherapy	
Family Therapy	
Group Therapy	
TBOS	
Case Management	

How I will know that I am ready to stop therapy? (Discharge criteria)

1. _____
2. _____
3. _____

Client Signature: _____

Client Guardian Signature: _____

Clinician Signature: _____

Clinician Superviser Signature: _____