Family Service Society, Inc.

| "√" if SCANNED TO EMR | INITIALS |
|---|---|
| *Return to Front Desk if not √ Checked and Initialed* | |

# Client's Biopsychosocial Assessment – Adult ONLY

**Client Name:** _____ **Date of Birth:** ____/____/____

**Guardian Name** *(if applicable)*: _____

**Race / Ethnicity:**

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Two or More Races ☐ Asian
☐ Native Hawaiian and Other Pacific Islander ☐ Prefer not to disclose ☐ Other_____

**Marital History:**

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower ☐ Re-Married ☐ Prefer not to disclose
☐ Other_____

**Gender Identity / Expression:**

☐ Male ☐ Female ☐ Male-to-Female/Transgender ☐ Female-to-Male/Transgender
☐ Genderqueer, neither exclusively male nor female ☐ Prefer not to disclose
☐ Other_____

**Sexual Orientation:**

☐ Straight or Heterosexual ☐ Homosexual, Gay, or Lesbian ☐ Bisexual ☐ Prefer not to disclose
☐ Other_____

**Current Living Situation** (*check 1*)**:**

☐ Own Home ☐ Foster Care ☐ Relative Placement ☐ Legal Guardian ☐ Pre-Adoptive Home
☐ Emergency Shelter ☐ Group Home ☐ Jail/Juvenile Detention
☐ Other_____

**History of Living Situations (check any that have ever applied):**

☐ Own Home/parent's home as an adult ☐ Foster Care ☐ Relative Placement as a child
☐ Legal Guardian ☐ Pre-Adoptive Home ☐ Emergency Shelter ☐ Group Home ☐ Jail/Juvenile Detention
☐ Other_____

**Supportive Individuals:**

| Name: | Relationship: | Age: | Quality of Relationship: |
|---|---|---|---|
| | | | ☐ Generally Positive ☐ Great ☐ Excellent |
| | | | ☐ Generally Positive ☐ Great ☐ Excellent |
| | | | ☐ Generally Positive ☐ Great ☐ Excellent |
| | | | ☐ Generally Positive ☐ Great ☐ Excellent |

**Education History:** (*Highest Completed Education*)

☐ High School ☐ GED ☐ Some College ☐ College ☐ Masters/PHD
☐ IEP - Individualized Education Program ☐ Dropped Out

**Legal Status / Criminal History:**

☐ None Reported ☐ Arrested ☐ Current Probation/Parole ☐ Past Probation/Parole

Charges: _____ ☐ Sentencing ☐ Dismissed

Time Served: _____

☐ Current Court Involvement (details) _____
☐ Previous Court Involvement (details) _____
☐ Previous Child Welfare Services Involvement (details) _____

**Employment History:**

☐ Part-Time ☐ Full-Time ☐ Unemployed ☐ Retired ☐ Veteran ☐ Active Duty ☐ N/A

Current Employment: _____

Previous Employment: _____

**Financial Status:**

Do you receive public assistance (i.e. WIC, SNAP, TANF? ) ☐ Yes ☐ No

Do you worry about money or making your bills? ☐ Yes ☐ No

Do you have a budget? ☐ Yes ☐ No

**Access to Transportation:**
What kind of transportation do you use to get to and from work, school, and/or your appointments?

_____

Are there times when a lack of transportation prevents you from attending work, school, or your important appointments? ☐ Yes ☐ No

**Access to Resources:**
What are some of the agencies or examples of community involvement or agencies that you've been involved with over the past few months/years?

_____

**Family Safety and Interactions:**

Do you feel emotional support within your family?

☐ Yes ☐ No

How do you feel your family handles conflict?

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Does anyone in the household regularly push, slap, grab or throw something at you?

☐ Yes ☐ No

Has anyone in the household struck you hard enough that marks were left or were you injured?

☐ Yes ☐ No

What are your daily family routines? (e.g. family dinner, bedtimes, morning routines, etc.)

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How do you celebrate birthdays, holidays, or other cultural traditions?

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**Mental Health Diagnosis & Treatment History:**

Diagnosis _____ Treatment _____ Length of Treatment _____

☐ Is this current? = How do you feel you are doing & is Diagnosis being managed: ○ Good ○ Fair ○ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

☐ Is this current? = How do you feel you are doing & is Diagnosis being managed: ○ Good ○ Fair ○ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

☐ Is this current? = How do you feel you are doing & is Diagnosis being managed: ○ Good ○ Fair ○ Poor

Diagnosis _____ Treatment _____ Length of Treatment _____

☐ Is this current? = How do you feel you are doing & is Diagnosis being managed: ○ Good ○ Fair ○ Poor

**Wellness Assessment(s) – Current symptoms within the last week:**

# Wellness Assessment – Adult ONLY!

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

*For questions 1-16, please think about your experience in the past week.*

| How much did the following problems bother you? | Not at All | A Little | Somewhat | A Lot |
|---|---|---|---|---|
| 1. Nervousness or shakiness | ○ | ○ | ○ | ○ |
| 2. Feeling sad or blue | ○ | ○ | ○ | ○ |
| 3. Feeling hopeless about the future | ○ | ○ | ○ | ○ |
| 4. Feeling everything is an effort | ○ | ○ | ○ | ○ |
| 5. Feeling no interest in things | ○ | ○ | ○ | ○ |
| 6. Your heart pounding or racing | ○ | ○ | ○ | ○ |
| 7. Trouble sleeping | ○ | ○ | ○ | ○ |
| 8. Feeling fearful or afraid | ○ | ○ | ○ | ○ |
| 9. Difficulty at home | ○ | ○ | ○ | ○ |
| 10. Difficulty socially | ○ | ○ | ○ | ○ |
| 11. Difficulty at work or school | ○ | ○ | ○ | ○ |

| How much do you agree with the following? | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| 12. I feel good about myself | ○ | ○ | ○ | ○ |
| 13. I can deal with my problems | ○ | ○ | ○ | ○ |
| 14. I am able to accomplish the things I want | ○ | ○ | ○ | ○ |
| 15. I have friends or family that I can count on for help | ○ | ○ | ○ | ○ |

16. In the past week, approximately how many drinks of alcohol did you have? ☐☐ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition: ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ☐☐ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* ☐☐ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No

**Medical History:**

Medication(s):

| Drug Name: | Reason: | Current: | Helpful/Effective |
|---|---|---|---|
| | | Yes No | Yes No |
| | | Yes No | Yes No |
| | | Yes No | Yes No |
| | | Yes No | Yes No |
| | | Yes No | Yes No |
| | | Yes No | Yes No |

History of Hospitalization(s) (*physical or mental health related*):

| Hospital: | Reason: | Diagnosis: | Helpful/Effective |
|---|---|---|---|
| | | | Yes No |
| | | | Yes No |
| | | | Yes No |
| | | | Yes No |
| | | | Yes No |
| | | | Yes No |

**Additional Medication(s):**

**Allergies:**

**Current Health/Medical Conditions:**

**Previous Health Conditions:**

**Disabilities:** ☐ N/A

| |
|---|
| |

**Conditions That May Impact Counseling** (*issues of concern*):

☐ Dental ☐ Vision ☐ Hearing ☐ Other _____

**Substance Abuse History:** ☐ N/A

| Substance: | Typical Amount Used: | Duration of Use/Abuse: | |
|---|---|---|---|
| | | | ☐ Current |
| | | | ☐ Current |
| | | | ☐ Current |
| | | | ☐ Current |
| | | | ☐ Current |

| | | | | |
|---|---|---|---|---|
| Drug of Choice: | | | | ☐ Current |

**Treatment Preferences** (*include individual needs*):

☐ Individual ☐ Family ☐ Group ☐ Other _____

**Personal / Family Strengths:**

| |
|---|
| |

**Abilities/Interests:**

| |
|---|
| |

_____ / /

**Client (Guardian) Signature** **Date**