Patient name________________________________ Date______________________

BIOPSYCHOSOCIAL HISTORY

Presenting problems: ________________________________

Duration (months): ________________________________

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)
0-NONE = This symptom not present at this time • 1-MILD = Impacts quality of life, but no significant impairment of day-to-day functioning 2-MODERATE = Significant impact on quality of life and/or day-to-day functioning • 3-SEVERE = Profound impact on quality of life and/or day-to-day functioning.

SYMPTOM LIST	Scoring	SYMPTOM LIST	Scoring
Depressed Mood		Immature	
Appetite Disturbance		Oppositional Behavior	
Sleep Disturbance		Sexual Dysfunction	
Chronic lying		Grief	
Fatigue/Low Energy		Hopelessness	
Poor Concentration		Social Isolation	
Poor Grooming		Worthlessness	
Mood Swings		Guilt	
Agitation		Elevated Mood	
Stealing		Hyperactivity	
Irritability		Dissociative States	
Generalized Anxiety		Self Mutilation	
Panic Attacks		Weight loss/gain	
Violent Temper		Emotional trauma victim	
Obsessions/Compulsions		Physical trauma victim	
Binging/Purging		Sexual trauma victim	
Laxative Abuse		Emotional trauma abuser	
Anorexia		Physical trauma abuser	
Paranoid Ideation		Sexual trauma abuser	
Hostile/Angry Mood		Substance abuse	
Indecisive		Self Injurious Acts	
Delusions		Impulsive	
Hallucinations		Fire Setting	
Aggressive Behaviors		Hyperactive	
Animal Cruelty		Assaults Others	
Break Things		Often Sad	
Not Trustworthy		Drug Use	
Alcohol Use		Distrustful	
Extreme Worrier			

Family alcohol/drug abuse history: check all that apply

	Father
	Mother
	Grandparent(s)
	Stepparent/live in
	Uncles/ Aunts
	Siblings
	Spouse/Significant other

Substances used: (complete all that apply)

	First age of use	Last age of use	Frequency	Amount
Alcohol				
Amphetamines				
Barbiturates				
Caffeine				
Cocaine				
Crack cocaine				
Hallucinogens				
Inhalants				
Marijuana/hash				
Nicotine				
PCP				
Prescription				
Other: Meth				

Name of parents: ______________________________

Name of siblings: ______________________________

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Name and ages of children: ______________________________

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Marriage/divorce history: ______________________________

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Educational history: ______________________________

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Surgeries, allergies and medical concerns: + list medications

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