Adult Outpatient Biopsychosocial History

Identifying Data

Patient's Name: _____ DOB: _____ Age: _____

Address: _____ Phone: _____

Legal Guardian/POA: _____ Scope: _____ Surrogate: _____

Race/Ethnicity: _____ Marital Status: _____ Sex: _____

Employer: _____ Method of Payment: Insurance _____ Public Aid: _____ Other: _____

Living Arrangements: _____ Height: _____ Weight: _____

Chief Complaint

In your words, describe your reason for seeking treatments: _____

_____

_____

_____

_____

Developmental History

Place of birth: _____ Birth Order: _____

Father's Name: _____ Age: _____ Job/Profession: _____

Medical problems: _____

Mother's Name: _____ Age: _____ Job/Profession: _____

Medical problems: _____

Siblings – (Full, Half or Step)

Brother's Name	***Age***	***Relationship***	***Sister's Name***	***Age***	***Relationship***

Any history of being abused, neglected as a child or adolescent: _____

☐ Physically ☐ Emotionally ☐ Sexually Explain: _____

Were there any other significant traumas while growing up? _____

Explain: _____

Was there any past history in the family you grew up in of substance abuse or psychiatric illness? ☐ Yes ☐ No

Explain: _____

_____

*Mark any problems by family members:

	Self	Father	Mother	Brother	Sister	Paternal GP	Maternal GP	Aunt	Uncle	Cousins
Nervous Tension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse or Overuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chemical Abuse or Misuse (Rx/street)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Violent or uncontrollable temper	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Assaulting Others	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric History	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Hospitalization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Educational/Vocational

Where did you attend school: _____ Highest level of education achieved: _____

Did you have any learning problems? ☐ Yes ☐ No Were you in any special education classes? ☐ Yes ☐ No

Any additional training or education, if so explain: _____

Employment History

Current Employment or source of income: _____

Prior jobs: _____ Dates of employment: _____ Quit/Fired: _____

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How do you rate your current job satisfaction? _____ Any job performance issued? _____

How do you get along with co-workers and supervisors? _____

Any specific career goals or aspirations? _____

Marital/Relational History

Marriages/Cohabitations/Separations/Divorces and length of involvement in each relationship starting with the most recent:

Recent: _____ Length: _____

Children, Bio or step and age(s): _____

Reasons(s) for ending of relationship: _____

Past: _____ Length: _____

Children, Bio or step and age(s): _____

Reasons(s) for ending of relationship: _____

Past: _____ Length: _____

Children, Bio or step and age(s): _____

Reasons(s) for ending of relationship: _____

How do you feel about the current relationship? _____

Has there been any physical, emotional, sexual abuse in the current relationship? If so, explain: _____

_____

Sexual History

Gender identity: _____ Sexual orientation: _____ Any problems with sexual functioning? _____

Is there any history of being abused or being an abuser? _____

Do you practice safe sex? _____

Military History

Branch: _____ Volunteer or Draftee? _____ Dates Served: _____

Type of Discharge: _____ Any service connected disability? _____

Spiritual/Religious

Were you raised in any particular religious or spiritual belief? _____

If attending, has your faith or belief changed? _____

Do you believe in a higher power? If so, does that power have a name? _____

Do you pray or meditate? _____

Leisure/Hobbies

Hobbies or activities you enjoy: _____

Are you involved in any community groups, clubs or organizations? _____

Legal History

Describe any current or past arrests, convictions, incarcerations. Any supervision, probation or parole: _____

_____

If currently on probation, name of office: _____

Emotional/Functionality

Do you have difficulty expressing your emotion? _____ Explain: _____

_____

Do you function at age appropriate development level? _____

Describe average daily activities: _____

_____

Meals/appetite: _____ Sleep pattern: _____ Levels of activity: _____

Do you have mobility or sensory difficulties? _____

Describe your support system and/or significant others in your life: _____

_____

Medical History

Name of current medical physician: _____

Name of any medical specialist consistently seen: _____

Name of Psychiatrist, Psychologist, Therapist seen: _____

Date of last physical exam, if known: _____ Date of last Psych contact: _____

Date of last P.A.P.: _____ Date of last Mammogram: _____

Have you had an lab work recently? ☐ Yes ☐ No

Please list medical problems, operations, broken bones, brain trauma or injury: _____

_____

Any history of allergies of food, environment agents, or medications: _____

Medication: _____ Response: _____

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List all current non-psychiatric prescribed medications and over the counter medications taken: _____

_____

Medical History, Continued

Medication: _____ Frequency: _____ Dose: _____ Doctor: _____

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Medication: _____ Frequency: _____ Dose: _____ Doctor: _____

List all psychiatric medication prescribed:

Medication: _____ Frequency: _____ Dose: _____ Doctor: _____

Medication: _____ Frequency: _____ Dose: _____ Doctor: _____

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Please list known date and reasons for both medical and psychiatric hospitalizations: _____

_____

_____

Do you have any pain? ☐ Yes ☐ No Explain: _____

Substance Use Screening Questions

Please list the substances you currently use and the amounts and duration:

Tobacco _____ Caffeine _____ Alcohol _____

Marijuana _____ Cocaine _____ Methamphetamine _____

Acid _____ Heroin _____ Methadone _____

Opiates _____ Inhalants _____ Prescription Drugs _____

☐ Yes ☐ No Do you abuse alcohol or drugs?

☐ Yes ☐ No Have you ever felt you should stop or cut down on your use?

☐ Yes ☐ No Have you had it brought to your attention by family, friends, spouse, significant other that you may have a problem with use?

☐ Yes ☐ No Have you had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?