Clinician: **Wade Warden** **Biopsychosocial Intake Form**

Client Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Primary Language Spoken:_____

Email Address: _____

Name the presenting problem(s) for which you/your child are seeking help:

1. _____

2. _____

3. _____

What are your/your child's treatment goals?

_____

_____

Presenting Symptom Checklist (check box for any symptoms present) which may cause distress or impairment in Social, Occupational, or other important areas of functioning:

☐Depressed mood ☐Racing thoughts ☐Concentration/Forgetfulness
☐Impulsivity ☐Change in appetite ☐Excessive Guilt
☐Increased/Decreased libido ☐Angry Outbursts
☐Phobias ☐Fatigue ☐Increased Risky Behavior
☐Crying Spells ☐Excessive Worry ☐Excessive Energy ☐Increased Irritability
☐Low Self-Esteem ☐Cutting ☐Suspiciousness ☐Poor Social Interactions
☐Suspiciousness ☐Audio/Visual ☐Delusions (e.g.. Grandiose, etc.)
☐Loss of Interest (in previously enjoyed activities)
☐Sleep pattern disturbance (Hypersomnia/Insomnia) ☐Hallucinations
☐Hypervigilance ☐Flash Backs ☐Obsessions/Compulsions
☐Avoidance ☐Unintentional Weight Gain/Loss ☐Anxiety/Panic Attacks
☐Verbal/Physical/Aggressive Behavior
☐Other: _____

Are there any biological, psychological, and/or social concerns that can be attributed to his/her/your condition? ☐ Yes ☐ No
If yes, please explain:

_____

Suicide/Homicide Risk Assessment

Do you feel or have thoughts that you would like to harm yourself or someone else? ☐Yes ☐No

Have you thought about how you would kill yourself or someone else?_____

Is the method you would use readily available?_____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself or someone else? _____

Have you tried to kill or harm yourself or anyone else before? _____

If yes, please explain. _____

Have you ever had feelings or thoughts that you didn't want to live? ☐Yes ☐No

If YES, please answer the following. If NO, please skip to the next section.

Do you feel hopeless and/or worthless? _____

Do you currently feel that you don't want to live? ☐Yes ☐No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel that way? _____

On a scale of 1 to 10 (10 being the strongest), how strong is your desire to kill yourself currently?

_____ Would anything make it better?_____

Medical History

Allergies:_____

Current or over-the-counter medications or supplements: _____

_____

Current Medical Problems:_____

_____

Past medical problems, non-psychiatric hospitalizations, or surgeries: _____

_____

_____

Date and place of last physical exam:_____

Personal and Family Medical History

☐ Thyroid Disease	☐ Kidney Disease	☐ Cancer (type)_____
☐ Anemia	☐ Diabetes	☐ Fibromyalgia
☐ Liver Disease	☐ Asthma/Respiratory Problems	☐ Heart Disease
☐ Chronic Fatigue	☐ Stomach/Intestinal Problems	☐ Epilepsy or Seizures
☐ Chronic Pain	☐ High Cholesterol	☐ High Blood Pressure
☐ Head Trauma	☐ Liver Problems	

Other (Specify):_____

Condition: Which Family Member:

_____

_____

Is there any additional personal or family medical history? ☐Yes ☐No
If yes, please explain:

_____

_____

When your mother was pregnant with you, (or you were pregnant with your child), were there any complications related to this pregnancy? (Pre-, during and/or Peri-natal) ☐Yes ☐No
If yes, please explain:

_____

_____

Are you (or your child) current with all immunizations? ☐Yes ☐No
If no, please explain:

_____

Past Psychiatric History

Outpatient treatment? ☐Yes ☐No
If yes, please describe below when, by whom, and nature of treatment.

Reason: Dates Treated: By Whom:

_____

_____

_____

Psychiatric Hospitalization? ☐Yes ☐No
If yes, please describe for what reason, when, and where.

Reason: Dates Hospitalized: Where:

_____

_____

Past psychiatric medications:
IF you have ever taken any of the following medications, please indicate the dates, dosages, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants:

☐Prozac (fluoxetine) ☐Zoloft (sertraline) ☐Luvox (fluvoxamine)
☐Paxil (paroxetine) ☐Celexa (citralopram) ☐Lexapro (escitalopram)
☐Effexor (venlafaxine) ☐Cymbalta (duloxetine) ☐Wellbutrin (bupropion)
☐Remeron (mirtazapine) ☐Serzone (neazodone) ☐Anafranil (clominpramine)
☐Pamelor (nortriptyline) ☐Tofranil (imipramine) ☐Elavil (amitriptyline)

Mood Stabilizers:

☐Tegretol (carbamazepine) ☐Depakote (valproate) ☐Lithium
☐Lamictal (lamotrigine) ☐Topomax (topiramate)

Antipsychotic/Mood Stabilizer Medications:

☐Seroquel (quetiapine) ☐Zyprexa (olanzapine) ☐Geodon (ziprasidone)
☐Abilify (aripiprazole) ☐Clozril (clozapine) ☐Prolixin (tluphenazine)
☐Haldol (haloperidol) ☐Risperdal (risperidone)

Sedatives/Hypnotics:

☐Ambien (zolpidem) ☐Sonata (zaleplon) ☐Rozerem (ramelteon)
☐Restoril (temazepam) ☐Desyrel (trazadone)

ADHD Medications:

☐Adderall (amphetamine) ☐Concerta (methylphenidate) ☐Ritalin (methylphenidate)
☐Strattera (atomoxetine)

Anti-Anxiety Medications:

☐Xanax (alprazolam) ☐Ativan (lorazepam) ☐Klonopin (clonazepam)
☐Valium (diazepam) ☐Tranxene (clorazepate) ☐Buspar (buspirone)

List ALL current medications and how often you take them (If none, write none):

Medication Name	Total Daily Dosage	Estimated Start Date

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for: (check all that apply)
☐Bipolar Disorder ☐Depression ☐Anxiety ☐Anger ☐Suicide ☐Schizophrenia
☐Post-traumatic Stress Disorder ☐Alcohol Abuse ☐Other substance abuse ☐Violence

If yes, who had each problem?

Has any family member been treated with a psychiatric medication? ☐Yes ☐No
If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Substance Use

Have you ever been treated for alcohol or drug use or abuse? ☐Yes ☐No

If yes, for what substances? _____

If yes, where were you treated and when? _____

How many days per week do you drink alcohol? _____

What is the least number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks

you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ☐Yes ☐No

Have people annoyed you by criticizing your drinking or drug use? ☐Yes ☐No

Have you ever felt bad or guilty about your drinking or drug use? ☐Yes ☐No

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

Do you think you may have a problem with alcohol or drug use? ☐Yes ☐No

Have you used any street drug within the past three months? ☐Yes ☐No

If yes, which ones? _____

Have you ever abused prescription medication? ☐Yes ☐No

If yes, which ones? _____

Check if you have ever tried the following: (check all that apply)

☐Methamphetamine ☐Cocaine ☐Stimulants (pills) ☐Heroin ☐LSD or Hallucinogens
☐Pain Killers (not as prescribed) ☐Methadone ☐Alcohol ☐Ecstasy
☐Tranquilizers/sleeping pills
Other: _____

How many caffeinated beverages do you drink a day?

Coffee_____ Sodas_____ Tea_____

Tobacco History:

Have you ever smoked cigarettes? ☐Yes ☐No

Currently? ☐Yes ☐No

How many packs per day on average?_____ In the past? ☐Yes ☐No

How many years did you smoke?_____ When did you quit? _____

Do you smoke pipes or cigars or use chewing tobacco? ☐Yes ☐No In the past? ☐Yes ☐No

What kind?_____ How often per day on average? _____

How many years?_____

Family Background and Childhood History

Were you adopted? ☐Yes ☐No

Where did you grow up? _____

List your siblings and their ages: _____

_____

_____

What is/was your father's occupation? _____

What is/was your mother's occupation? _____

Did your parents divorce? ☐Yes ☐No

If so, how old were you when they divorced?_____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him. _____

_____

_____

Describe your mother and your relationship with her. _____

_____

_____

How old were you when you left home?_____

Has anyone in your immediate family died? ☐Yes ☐No

Who, When, and how? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, verbally, or by neglect?

☐Yes ☐No

Please describe when, where, and by whom, and was this abuse reported/investigated?

☐Yes ☐No

_____

_____

Have you witnessed domestic violence? ☐Yes ☐No

Education History:

Do you attend school or college? ☐Yes ☐No

If so, where do you attend and what grade are you in? _____

What is your highest level or degree attained? _____

Occupational History:

Are you currently: ☐Working ☐Student ☐Unemployed ☐Disabled ☐Retired

Where do you work? _____

How long in and what is your present position? _____

Have you ever served in the military? ☐Yes ☐No

If so, what branch and when? _____

What type of discharge? _____

Relationship History and Current Family:

Are you currently: ☐Married ☐Partnered ☐Divorced ☐Single ☐Widowed

How long?_____

If in a relationship, what is your spouse or significant other's occupation?

_____

Describe your relationship with your spouse or significant other:

_____

_____

Have you had any prior marriages? ☐Yes ☐No If so, how many?_____

How long?_____

Do you have any children? ☐Yes ☐No

If yes, list ages and gender:_____

_____

_____

Describe your relationship with your children: _____

_____

_____

List everyone who currently lives with you:_____

_____

_____

Legal History:

Have you ever been arrested? ☐Yes ☐No

Do you have any pending criminal charges? ☐Yes ☐No

If yes, please describe and provide current status: _____

_____

Are you currently involved in any lawsuits (custody battle, civil suits, divorce proceedings)?

☐Yes ☐No

If yes, please describe and provide current status: _____

_____

Discrimination:

Are you experiencing discrimination in any of these areas?

☐Age ☐Gender ☐Race ☐Sexual Orientation ☐Religion

Explain:_____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ☐Yes ☐No

If yes, what is the current level of your involvement? _____

Do you find your involvement helpful during time of struggle, or does involvement make things more difficultor stressful for you? ☐Helpful ☐More difficult

Is there anything else you would like us to know? _____

_____

[CLINICIAN USE ONLY]

Mini-Mental Status Exam:

Given: ☐Yes ☐No (See attached)

Clinical Diagnostic Impression: _____

_____

_____

_____

_____

Treatment Recommendations: _____

_____

_____

_____

_____

It has been determined by the undersigned therapist, that these services are medically necessary for the well-being of the client.

_____ _____

Client Signature Date

_____ _____

Guardian Signature (if applicable) Date

_____ _____

Clinician Date