Fountain of Hope Family Services Inc.

PRE- BIO – PSYCHOSOCIAL ASSESSMENT

DATE _____ FILE # _____

I. INTAKE INFORMATION

1. Client's name: _____

2. MEDICAID#_____

3. Home Address _____
Street

_____
City State Zip

4. Telephone: Home _____ Other _____

5. Date of Birth _____ 6. Age _____

7. S.S. # _____ 8. Race/Ethnicity _____

9. Gender _____ 10. Marital Status _____

11. Emergency Contact: _____

12. Relationship: _____ 13. Emergency Phone _____

14. DHS/OJA Custody? Yes_____ No_____

15. Employment Full time _____ Part time _____ Unemp. ____ Not in work force____

16. Occupational code Professional/Technical _____ Manager/Administrative _____
Skilled Worker_____ Unskilled Worker _____ Farmer _____ None _____

17. Referral Source & Number _____

Client Name: _____

18. Presenting Problem _____

19. History of Presenting Problem _____
_____
_____

20. Previous Treatment History and/or Diagnostic History (Include diagnoses, treatment information and dates):

Mental Health _____
_____

Substance Abuse _____
_____

Domestic Violence _____
_____

II. ASSESSMENT/INTERPRETATIVE SUMMARY - CURRENT

What assets does client have that will help him/her succeed in treatment? _____
_____

What are the possible barriers/roadblocks that may hinder client's progress in treatment?
_____

Type of treatment services needed: ☐ Individual/Interactive ☐ Family
☐Rehabilitation/Life Skills ☐Case Management ☐ Other _____

Frequency of Services Desired: ☐ Once weekly ☐ Twice weekly ☐Other _____

Preferred Location of Services: ☐ Home ☐ School ☐ Other _____

List any specialized skills, therapeutic knowledge, and/or tools to be provided in order to enhance treatment outcome: _____

Are there any referrals to and/or collaboration with another agency? Yes____ No____
If yes, list name and telephone number _____

Client Name: _____

Are there any co-occurring disabilities/disorders that will affect treatment? Yes___ No ___
If yes, what are they? _____
If yes, how will they be addressed in treatment? _____
_____

Are there any needs for assistive technology? Yes ___ No ____
If yes, how will they be addressed in treatment? _____
_____

Other pertinent information: _____
_____

III. HEALTH HISTORY/CURRENT BIOMEDICAL CONDITIONS

1. Any current medical/health problems? Yes _____ No _____

2. If yes—what is the diagnosis/problem(s)? _____
_____
_____

3. If applicable - What treatments are you receiving? _____
_____

4. Do you have an advanced directive? Yes _____ No _____
If so, how will it impact your treatment? _____
_____

5. Any disabilities that would effect your treatment? Yes _____ No _____
If yes, please describe: _____
_____
_____

6. Any allergies to medication? Yes ___ No ___ List_____
_____

7. Personal physician _____

Client Name: _____

8. Are you currently taking prescribed or over-the-counter medication? Yes___ No_____
If yes, list medications below:

Medication	Physician	Strength/Dosage	Date Initiated

9. How have you adjusted to treatment/medication? _____
_____

10. What present or past mediations were effective? Not effective? _____
_____
_____
_____
_____

IV. HISTORY OF VIOLENT BEHAVIOR/SUICIDAL TENDENCIES

1. Do you have a history of violent behavior? Yes_____ No _____
If yes, describe and include dates _____
_____
_____

2. Have you ever attempted suicide? Yes_____ No _____

If yes, describe and include dates _____

3. Do you currently have thoughts of hurting yourself or others? Yes_____ No _____

If yes, do you have a plan? Yes _____ No _____ N/A _____

If yes, what is it? _____

Client Name: _____

4. Any risk taking behaviors? Yes_____ No_____
If yes, please describe: _____
_____
_____

DOMESTIC VIOLENCE/ SEXUAL ASSAULT

1. Have you ever been a victim of emotional abuse and/or neglect?
Yes _____ No _____ If yes, describe: _____
_____

2. Have you ever been a victim of domestic violence and/or other physical abuse?
Yes _____ No _____ If yes, describe: _____

3. Have you ever been a victim of sexual assault /abuse? Yes _____ No _____
If yes, describe: _____
Who was the perpetrator? _____
Any resolve? Please explain: _____

4. Have you ever received counseling for sexual assault /abuse? Yes _____ No _____
If yes, describe: _____
How recent or how long ago? _____
Do you feel this has helped you Yes _____ No _____

V. FAMILY/MARITAL, SOCIAL HISTORY, LIVING SITUATION

1. Family Member/Name	Age	City/State	Current Relationship
Father			
Mother			
Sisters			
Brothers			
Spouse			

Client Name: _____

Children			

2. With whom do you currently live? _____Number in Home ____

3. Current Living Environment: ___ House ___ Apt ___ Duplex ___ Other: _____

4. Who have you lived with in the past? _____

5. Any significant childhood losses? Include divorce, death, and estrangement. _____
_____
Age of loss (es) _____
_____

6. Any history of alcohol/drug abuse or mental illness in family of origin?
Yes _____ No _____
If yes, list family member(s) _____

7. Have any family members been treated for any of the above? Yes_____ No_____
If yes, list family member(s) _____

8. Significant Other relationships: list year and length of relationship or marriage, year of separation or divorce, number of children: _____
_____
_____

9. Does significant other drink or use drugs? Yes _____ No _____ N/A _____

VI. EDUCATIONAL HISTORY

1. Last year completed _____ Name of school _____

2. Which grades, if any, did you repeat? _____

Client Name: _____

3. What vocational school or college have you attended? _____

4. List specialized training, if any _____

5. List and describe any suspensions or expulsions _____

II. CULTURAL/RELIGIOUS ORIENTATION

1. What is your race or ethnicity? Caucasian _____ African/American _____Asian ____
   Hispanic _____ Native American _____ Other _____

2. How will your cultural practices affect treatment? _____
   _____

3. What is your religious background? Protestant _____ Jewish _____ Catholic _____
   Other _____ None _____

4. Does client attend church on a regular basis? Yes _____ No _____

5. Spiritual beliefs and practice of same? _____

6. Are you a U.S. citizen? Yes _____ No _____
If no, how long have you been in the U.S.? _____

III. OCCUPATIONAL/MILITARY HISTORY (clients 16 years +) N/A _____

1. Employer _____ Job title _____
   Employer's address _____
   Employer's phone number _____How long employed? _____
   Other sources of income (i.e. SSI, disability, VA, retirement, child support, etc.):

_____
_____

Previous employment:
Employer Dates Title Reason for leaving

Client Name: _____

_____
_____
2. What kinds of work of are you qualified to perform? _____
_____

3. Have you ever been in the military? Yes _____ No _____
If yes, what branch, dates of service, and type of discharge? _____

IV. SEXUAL HISTORY N/A _____

1. Have you ever had a sexually transmitted disease? Yes _____ No _____
If yes, detail what, when, etc. _____

2. Are you currently sexually active? Yes _____ No _____ If yes, what form(s) of protection and/or birth control do you use? _____

3. Do you desire help obtaining services for infection screening? Yes _____ No _____
If yes, note counselor's report of action taken to assure the requested services: _____

4. Sexual orientation: _____

V. RECREATIONAL/LEISURE HISTORY

1. What do you currently like to do for recreation? _____

2. How have you spent your leisure time in the past? _____

VI. LEGAL HISTORY N/A _____

1. What is your current legal status? _____
_____

2. List chronologically any past convictions:

Offense	Felony/Misdemeanor	Age	Sentence	Jail Time

Client Name: _____

VII. ECONOMIC RESOURCES (adult clients) N/A _____

1. Do you own a home? Yes ____No ____ 2. Do you rent a home? Yes ____ No____

3. Do you own a car? Yes _____ No _____

4. How do you currently support yourself and your family financially? _____
_____
_____

VIII. CURRENT SUPPORT SYSTEM

1. To whom do you currently look for support? _____
_____

2. Do they support your entering treatment? _____

3. Are you experiencing severe isolation or withdrawal from social contact?
Yes _____ No _____ If yes, explain: _____
_____
_____

IX. CLIENT'S QUALITIES (client responses needed)

1. What are your strengths/abilities? (assets, resources, natural positives) _____
_____

2. What are your needs/liabilities? (weaknesses, what do you need to recover) _____
_____

3. What are your abilities/interests? (skills, aptitudes, capabilities talents, competencies)
_____

4. What are your preferences? (what will enhance treatment experience?) _____
_____

Client Name: _____

5. What do you expect from this program in terms of service? _____
_____

6. Therapist's expectations _____
_____
_____

XV. MULTIAXIAL DIAGNOSIS

AXIS I (code and condition): _____

AXIS II (code and condition): _____

AXIS III: _____

AXIS IV: _____

AXIS V (current): _____ AXIS V (past year): _____

_____
Clinician Signature & Credentials Date

Client Name: _____

BIOPSYCHOSOCIAL ADDENDUM
CHILDREN AND ADOLESCENTS

XVI. SCHOOL HISTORY

1. Are you currently enrolled in school? Yes _____ No _____

2. Present school attending/will attend _____ Grade level _____

3. Have you had to repeat a grade? Yes _____ No _____ If yes, what grade? _____

4. Have you ever been placed in special education classes or a resource room? Yes_____
   No _____ If yes, explain:_____

5. Have you been diagnosed with a learning disability? Yes _____ No _____

6. Do you have difficulty reading? Yes _____No _____

7. Do you have difficulty writing? Yes _____ No _____

8. How are your grades now? _____

Client Name: _____

9. Have you failed any classes in the past year? Yes _____No_____

10. Has your school performance changed? Yes _____No_____
If yes, explain: _____

11. Have you been suspended or expelled? Yes _____No _____
If yes, explain: _____

12. How many days did you miss school, the last semester you attended? _____

X. DEVELOPMENTAL HISTORY

1. Any problems at birth? _____

2. Prenatal exposure to alcohol, tobacco, or other drugs? Yes _____No _____
If so, explain: _____
Source of information: _____

3. Age first walked? _____

4. Age first talked? _____

5. Known developmental delays _____

6. Any hearing problems? Yes____ No____ Has this been tested? Yes ____ No _____

7. Any vision problems? Yes____ No ____ Has this been tested? Yes ____ No _____

8. Do you have problems with speech? Yes _____ No _____

9. Have you had any speech therapy? Yes _____ No _____

XI. FAMILY HISTORY/PLACEMENTS

Client Name: _____

1. Current legal custody or legal guardianship (may not be the same as current physical custody): Mother _____ Father _____ Joint _____ DHS _____ Other _____

2. With whom have you lived, and at what ages? _____

3. Note psychological problems of parents and other caretakers (list who and what):
_____

XII. IMMUNIZATIONS

1. Are immunizations currently up to date? Yes _____ No _____
Source of information _____

XIII. PEER INTERACTIONS

1. Who are your friends? _____

2. What do you like to do together? _____

3. Do any of them drink or use drugs? _____

4. Any problems with peers? _____

5. Comments_____

_____ _____
Therapist's signature/credentials Date

Client Name: _____