



Biopsychosocial History & Assessment  
Adult Self-Report (Part A)

Patient Name: \_\_\_\_\_

Instructions: Please answer the following questions to the best of your ability as this will be helpful for your therapist in better understanding your situation.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Racial Identity: (check all that apply)  
 American Indian or Alaska Native  
 Asian or Asian American  
 Other: \_\_\_\_\_  
 Hispanic or Latino  
 White  
 Native Hawaiian or Pacific Islander  
 Black or African American

**PRESENTING PROBLEM**

Check if you are experiencing any of the following problems:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Family / Friends            | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Drug abuse    | <input type="checkbox"/> Marital / Relationships     | <input type="checkbox"/> Physical health   |
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Sexual issues / Orientation | <input type="checkbox"/> Financial         |
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Eating habits               | <input type="checkbox"/> Gambling issues   |

We would appreciate learning more about you and your perspective on your life. Please describe, in detail, why you checked the above items. Tell us about your challenges, strengths, your needs and any family or community support you have in your life:

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What goals would you like to accomplish in treatment:

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_

**SYMPTOM CHECKLIST**

The following is a list of symptoms that have to do with various psychological problems. Please circle the number from zero (0) to four (4) that best describes how much this symptom or problem bothers you. Use the following scale:

**0 = Not at all    1 = A little bit    2 = Moderately    3 = Quite a bit    4 = Extremely**

**In the past week, how much were you bothered by:**

	Not at all	Moderately	Extremely
1. Feeling depressed, sad, blue, down, unhappy most of the time	0	1	2 3 4
2. Feeling easily annoyed or irritated	0	1	2 3 4
3. Feeling no interest in things or avoiding enjoyable activities, family, or friends	0	1	2 3 4
4. Feeling tired all the time even with adequate sleep	0	1	2 3 4
5. Trouble concentrating: can't stay focused on activities	0	1	2 3 4
6. Feeling lonely even when you are with people	0	1	2 3 4
7. Feeling hopeless about the future	0	1	2 3 4
8. Significant increase or decrease in appetite or weight	0	1	2 3 4
9. Sleeping problems: can't fall asleep, restless sleep, sleeping too much	0	1	2 3 4
10. Thoughts of suicide: thinking "I wish I were dead," "life isn't worth living anymore"	0	1	2 3 4
11. Suicide attempt: intent or action to hurt or kill self with pills, weapons, cuts, etc.	0	1	2 3 4
12. Racing thoughts, rapid speech, little or no need for sleep, impulsive traveling and/or spending money	0	1	2 3 4
13. Doing things without thinking and often getting yourself into a jam	0	1	2 3 4
14. Feeling so restless you could not sit still	0	1	2 3 4
15. Feeling anxious: worrying excessively or worry about many things	0	1	2 3 4
16. Feeling tense or keyed up	0	1	2 3 4
17. Spells of terror or panic	0	1	2 3 4
18. Fearful feelings of being humiliated in social situations	0	1	2 3 4
19. Feeling uneasy in crowds or in open spaces	0	1	2 3 4
20. Feeling afraid to travel on buses, subways, trains, or planes	0	1	2 3 4
21. Feeling inferior to others	0	1	2 3 4
22. Having to avoid certain things, places or activities because they frighten you	0	1	2 3 4
23. Sudden re-experiencing of feelings, thoughts, images of a traumatic event	0	1	2 3 4
24. Temper outbursts that you could not control	0	1	2 3 4
25. Feeling "nothing" or numb, as if blocked as in taking a pain killer	0	1	2 3 4
26. Recurrent thoughts, impulses, or images that are intrusive and troubling	0	1	2 3 4
27. Excessive repeating of an activity that you couldn't resist even though it sometimes seems foolish (e.g., cleaning, washing hands, counting, etc.)	0	1	2 3 4
28. Feeling that you are watched or talked about by others	0	1	2 3 4
29. Seeing or hearing things outside yourself that others tell you are not really there	0	1	2 3 4
30. The idea that someone else can control your thoughts	0	1	2 3 4



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31. Feeling that most people cannot be trusted	0	1	2	3	4
32. Persistent fears about health problems despite doctors finding nothing wrong	0	1	2	3	4
33. Episodes of binge eating, purging/vomiting, or periods of not eating	0	1	2	3	4
34. Feeling others are to blame for most of your troubles	0	1	2	3	4
35. Having urges to break or smash things or injure someone	0	1	2	3	4
36. Getting into frequent arguments with family members, friends or co-workers	0	1	2	3	4
37. Difficulty managing children, feel parenting skills are deficient	0	1	2	3	4
38. Occupational concerns: job dissatisfaction, problems with employer/co-workers	0	1	2	3	4
39. Other:	0	1	2	3	4

For the next several questions, please circle the number that represents how frequently you use any of the following substances. Use the following scale:

**0 = Never    1 = In past, not currently    2 = Monthly    3 = Weekly    4 = Almost daily**

	Never	In Past	Monthly	Weekly	Daily
a.Caffeine: coffee, caffeinated beverages	0	1	2	3	4
b.Nicotine: cigarettes, cigars	0	1	2	3	4
c.Beer / Liquor	0	1	2	3	4
d.Marijuana, hash	0	1	2	3	4
e.Sedatives: tranquilizers, sleeping pills, barbiturates, valium, xanax, Quaaludes	0	1	2	3	4
f.Inhalents / Solvents: glue, toluene, gasoline	0	1	2	3	4
g.Stimulants: amphetamines, "speed", Ritalin	0	1	2	3	4
h.LSD, psychedelics, mescaline, peyote, DMT, ecstasy	0	1	2	3	4
i.Cocaine / Crack / Crank, coca leaves	0	1	2	3	4
j.Opioids: herion, codeine, Demerol, morphine, percodan, methadone, darvon, oxycodone	0	1	2	3	4
k.PCP, "angel dust"	0	1	2	3	4
l.Other:	0	1	2	3	4

**PSYCHOLOGICAL HISTORY**

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? Yes    No  
 If yes, what and when: \_\_\_\_\_

Have you ever been in counseling or psychotherapy before? Yes    No  
 If yes, where and when: \_\_\_\_\_

Have you had any past hospitalizations for emotional problems? Yes    No  
 If yes, when and where: \_\_\_\_\_

Have you ever intentionally hurt yourself or made a suicide attempt? Yes    No  
 If yes, explain how and when: \_\_\_\_\_



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**MEDICAL HISTORY**

Check if you are currently experiencing or have ever experienced:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Head injury                       | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Asthma or hay fever              |
| <input type="checkbox"/> Heart (trouble, disease, surgery) | <input type="checkbox"/> Thyroid problem            | <input type="checkbox"/> Sinus problems                   |
| <input type="checkbox"/> Heart murmur                      | <input type="checkbox"/> Kidney or bladder problems | <input type="checkbox"/> Weight change/change in appetite |
| <input type="checkbox"/> Heart pacemaker                   | <input type="checkbox"/> Liver disease              | <input type="checkbox"/> Glaucoma/Cataracts               |
| <input type="checkbox"/> Rheumatic fever or heart disease  | <input type="checkbox"/> Jaundice/rashes/sores      | <input type="checkbox"/> Neurological disorders           |
| <input type="checkbox"/> Abnormal blood pressure           | <input type="checkbox"/> Hepatitis – type A B C     | <input type="checkbox"/> Memory loss                      |
| <input type="checkbox"/> Ulcers/abdominal pain             | <input type="checkbox"/> Arthritis / Rheumatism     | <input type="checkbox"/> Venereal disease                 |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> HIV positive / AIDS / ARC        |
| <input type="checkbox"/> Epilepsy (Seizure Disorder)       | <input type="checkbox"/> Hemophilia/blood disease   | <input type="checkbox"/> Hearing impaired                 |
| <input type="checkbox"/> Tuberculosis or lung disease      | <input type="checkbox"/> Sickle Cell disease        | <input type="checkbox"/> Visual problems                  |
| <input type="checkbox"/> Emphysema                         | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Broken bones                     |
| <input type="checkbox"/> Cancer / tumors                   | <input type="checkbox"/> Fainting spells            | <input type="checkbox"/> Other _____                      |

If you checked any of the above medical items, please explain:

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Are you currently experiencing any physical pain? Yes    No  
 If yes, where is the pain: \_\_\_\_\_

Are you currently receiving care for your pain? Yes    No  
 By whom: \_\_\_\_\_

Do you have any allergies or reactions to medication? Yes    No  
 If yes, what medications: \_\_\_\_\_

Who is your primary care physician: \_\_\_\_\_

Are you taking any prescribed medications? Yes    No

Name of medication	Dosage and Frequency	Reason	Physician

Please indicate any herbal or homeopathic substances that you are currently taking: \_\_\_\_\_

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**FAMILY HISTORY**

Please list Parents, Siblings, Spouse/Partner, Children, and Significant Relatives/Others:

Name (First & Last)	Relationship	Age	School / Occupation	City of Residence

How many pregnancies have you experienced? \_\_\_\_\_

Marital Status:  Never married    Long-term relationship    Married    Divorced    Separated    Widowed

Number of marriages: \_\_\_\_\_      If married, how long? \_\_\_\_\_

If past divorce, when and why? \_\_\_\_\_  
 \_\_\_\_\_

Who currently lives in your household? \_\_\_\_\_  
 \_\_\_\_\_

Is there a history of depression, anxiety, alcoholism, or other mental health conditions in your family?      Yes      No  
 If yes, who? What was the problem? Did they receive treatment or medication? \_\_\_\_\_  
 \_\_\_\_\_

Have you ever experienced any emotional, physical, or sexual abuse?      Yes      No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been accused of assaulting or inappropriately touching someone?      Yes      No  
 If yes, please explain who / when: \_\_\_\_\_  
 \_\_\_\_\_

Does the use of alcohol or drugs by someone close to you contribute to your problems?      Yes      No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Did you grow up in a home in which a parent abused alcohol or drugs?      Yes      No



**EDUCATIONAL & VOCATIONAL HISTORY**

What is your highest grade level completed? \_\_\_\_\_ Do you have a GED in lieu of diploma? Yes No

How did you do academically in school? \_\_\_\_\_

How was your conduct throughout school? \_\_\_\_\_

If attended college, where and what is your degree? \_\_\_\_\_

What is your occupation / job? \_\_\_\_\_ For how long? \_\_\_\_\_

Have you ever been fired? Yes No If yes, explain: \_\_\_\_\_

Do you have any current financial problems? Yes No If yes, explain: \_\_\_\_\_

Do you have any language or reading difficulties? Yes No If yes, explain: \_\_\_\_\_

**MILITARY HISTORY**

Did you ever serve in the military? Yes No Branch of Military: \_\_\_\_\_

Date / Type of Discharge: \_\_\_\_\_ Do you have any combat history? Yes No

**LEGAL HISTORY**

Do you have a legal history consisting of past or current:

Arrests Yes No Explain: \_\_\_\_\_

Restraining Order Yes No Explain: \_\_\_\_\_

Divorce / Custody Yes No Explain: \_\_\_\_\_

Incarceration Yes No Explain: \_\_\_\_\_

Probation Yes No Explain: \_\_\_\_\_

**CULTURAL / RELIGIOUS / SPIRITUAL HISTORY**

What is your ethnic or cultural heritage? \_\_\_\_\_

In what religion did you grow up? \_\_\_\_\_ Your current religion? \_\_\_\_\_

How does your ethnicity or religious beliefs influence your life? \_\_\_\_\_

Signature of person completing this form:

\_\_\_\_\_ Date \_\_\_\_\_



Dear Valued client of *Center for Behavioral Medicine*,

This letter is to inform you of a new policy that will be going into effect as of **May 1, 2016**. In lieu of printing handouts, worksheets and other treatment materials, we will instead be providing new, spiral-bound copies of Marsha Linehan's *DBT Skills Training Handouts and Worksheets* for each identified adult client at our clinic, or a copy of Miller and Rathus' *DBT Skills Training Manual for Adolescents* for our adolescent clients and their families.

As part of this newer, more environmentally-friendly process, there will be a **one-time materials fee of \$50.00 per client/family**, which will cover any and all of the materials we will continue to provide for you at CBM to facilitate your care and treatment. Please be advised that the materials fee will be collected at the time of your initial appointment.

It is our hope that implementing this small change in the way our clinic functions will benefit both clients and providers in the effective practice of DBT.

Thank you,  
The Center for Behavioral Medicine Team

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Signature

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Date