Center for Behavioral Medicine

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:

- ☐Alcohol abuse
- ☐Drug abuse
- ☐Anxiety
- ☐Depression
- ☐Family / Friends
- ☐Marital / Relationships
- ☐Sexual issues / Orientation
- ☐Eating habits
- ☐Stress management
- ☐Physical health
- ☐Financial
- ☐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:

What goals would you like to accomplish in treatment:

1. _____
2. _____
3. _____
4. _____

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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:

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

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

_____

_____

_____

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

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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 _____

Center for Behavioral Medicine

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

Signature _____ Date _____