NAME____DATE___________

Biosocial Assessment Part 1

Provider Information

Margaret Joan McCloskey MS LMFT/License number: LMFT 22594
Address: 25255 Cabot Road, Suite 228, Laguna Hills, CA 92653 Phone: (949-837-6970)

Date of Assessment: ________________

The assessment completed by interactive discussion between client and clinician.

Purpose of assessment: ☐ New Client ☐ Reevaluation Review
Those attending assessment session: ☐ Client only ☐ Others: names/relationship(s): _______________________

Demographic Information

Client Name: (First)__________________(Middle)_______________(Last)________________________________

Address (City, State, Zip Code):____

Date of Birth: ________ Age: ____ Social Security number: _______________________________________
Home phone: ☐ None ( ) ______________________ Okay to call/leave message? ☐Yes ☐No
Cell phone: ☐ None ( ) ______________________ Okay to call/leave message? ☐Yes ☐No
Work phone: ☐ None ( ) ______________________ Okay to call/leave message? ☐Yes ☐No
Which phone number do you prefer I use to contact you? ☐ Home ☐ Work ☐ Cell

Signature:____ Date:_______________________

Date of first appointment: ________________ Total minutes: ____________________________________
Beginning time: ________________ AM/PM Ending time: ____________________ AM/PM

Counseling client is seeking: ☐ Adult therapy ☐ Child Therapy ☐ Couple Therapy
☐ Family Therapy ☐ Drugs and Crisis Intervention ☐ Other: __________________
Contact setting: ☐ Professional Office ☐ Other _____________________________

Gender Orientation

Gender: ☐ Male ☐ Female ☐ Transgender M-F ☐ Transgender F-M ☐ Other
Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Asexual ☐ Questioning
☐ Prefer not to say ☐ Transgender ☐ Other:______________________

Referral Source

Who gave you my name to call? Name: ______________________________________Phone: _________________

Relationship History and Current Family

Are you currently:
☐ Single ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Live-in-Partner ☐ Significant Other (not living together) ☐ Other: ___________________________________

If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long?___________________________
Are you sexually active? ☐ Yes ☐ No
What is your current level of satisfaction in the relationship? (Rate 1-10) __________________________________
Rate your level of commitment to the relationship (1-10): ____
Current Partner's Name/Occupation: ☐ N/A ____
Age: _______________ Length of Relationship: ____
Have you had any prior marriages? ☐ Yes ☐ No If so, how many and how long?_____________________________
Do you have children? ☐ Yes ☐ No If yes, list ages and genders:____
____

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Describe your relationship with your children: ____
List everyone who currently lives with you (name, age, relationship): ____________________________
Primary language of household/family: ____
Have you ever been or caused emotionally, mentally or physically abused by a romantic partner? ☐Yes ☐No
Do any of these apply to your current relationship? ☐ Yes ☐ No Do you feel safe? ☐ Yes ☐ No
If you answered yes to any of the above, please explain:____
____

Spouse/Partner
Name: (First)_________________(Middle)______________(Last)_______________________________

Address (City, State, Zip Code):____

Date of Birth: ________ Age: ____ Social Security number: ______________________________
Home phone: ☐ None ( ) ______________________ Okay to call/leave message? ☐Yes ☐No
Cell phone: ☐ None ( ) ______________________ Okay to call/leave message? ☐Yes ☐No
Work phone: ☐ None ( ) ______________________Okay to call/leave message? ☐Yes ☐No
Which phone number do you prefer I use to contact you? ☐ Home ☐ Work ☐ Cell
Relationship status: ☐ Single ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Live-in-Partner ☐ Significant Other (not living together) ☐ Other: ____________________________
Occupation/Employer: ____
Prior marriages: ☐ Yes ☐ No If so, how many and how long?___________________________________

Family of Origin

Childhood Development

Milestones

Were Motor/Walking Milestones met at appropriate age? Yes ☐ No ☐
Were vocalizations/Talking Milestones met at appropriate age? Yes ☐ No ☐

Did the patient have friends as a child? Yes ☐ No ☐ Few ☐ None ☐

Did the patient have friends currently? Yes ☐ No ☐ Few ☐ None ☐

Describe childhood family experience

☐ outstanding home environment
☐ normal home environment
☐ chaotic home environment
☐ witnessed physical/verbal/sexual abuse toward others
☐ experienced physical/verbal/sexual abuse from others

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, with whom did you live? ____
Describe your father and your relationship with him? ____
Describe your mother and your relationship with her? ____
How old were you when you left home? ___________
Any children live outside the home? Please list names and ages: ______________________________
Has anyone in your immediate family died? ☐ Yes ☐ No

Who?	From what?	When?

Were you sexually abused or neglected as a child? ☐ Yes ☐ No If yes, please explain:
____

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Risk Factors

Please check any risk factors that apply to you:

☐ Domestic Violence ☐ Cutting or other self-harm ☐ Child Abuse ☐ Elder abuse
☐ Prior behavioral health inpatient admissions ☐ Eating disorder ☐ History of multiple behavior diagnosis
☐ Sexual abuse ☐ Suicide/homicidal ideation ☐ N/A ☐ Other ____

Your Family Medical History

Reference in the table below you, parents, step-parents, siblings, grandparents, uncles, aunts, and any illnesses:
☐ N/A

Health Issue	You	Family	Which Family member?
Thyroid Disease			
Chronic Fatigue			
Kidney Disease			
Diabetes			
Asthma/Respiratory			
Cancer (type)			
Fibromyalgia			
Heart Disease			
Chronic Pain			
High Cholesterol			
High Blood Pressure			
Head Trauma			
Other			

Your Family Psychiatric History (Mental health and chemical dependency)

Has any relative had inpatient treatment for a psychiatric, emotional or substance use disorder? ☐ Yes ☐ No ☐ N/A
If yes, please describe in the table below:

Name/Relationship	For what? (diagnosis)	What kind of treatment?	Where or form whom?	When? (Dates)	With what results?

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Your Past Psychiatric History
(Mental health and chemical dependency)

Have you ever received inpatient or outpatient psychological, psychiatric, drug/alcohol treatments, medications, or counseling services before? □ Yes □ No □ N/A If yes, please describe in the table below:

When? (Dates)	For what? (diagnosis)	What kind of treatment?	Name of Doctor/ Psychiatrist Phone number	With what results?

Other Behavioral Health Specialists or Consultants

□ N/A
Name: ____ Phone: _________________________
(Use back of sheet if necessary.)

Your Substance Abuse, Sexual and Other Risk Factors

Substance abuse history (Complete for all patients age 12 and over.) □ N/A

Substance	Amount	Frequency	Duration	First Use	Last Use	Comments
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Prescription mediation						
Opioids/Narcotics						
Amphetamines						
Cocaine						
Heroine						
Meth						
Others						

Has anyone been concerned with your alcohol/drug use? □ Yes □ No If so, who?__________________________

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Your Medical Care

(Use back of paper if necessary.)
From whom or where do you get your medical care? ____
Clinic/Doctor's name: ____ ☐ N/A
Address: _________________________________ Phone:_______________________
Patient does _______/does not_______ give me permission to contact the above provider for coordination of care purposes. If you checked "does not," why? ☐ Prefer to maintain privacy with this issue.
☐ Other: ____
What was the date and the results of your last medical exam?___________________________
I would rate my current health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor
If you rated yourself as less than good, please explain: _______________________________

List All Current Medical problems in the table below: ☐ N/A if none

Medical Problem	When Diagnosed	Outcome

List ALL current medications that you are taking in the table below: ☐ N/A if none

Medication, Supplements Over-the-Counter Medications and/or Herbs	Prescribing Doctor

Compliance with taking prescribed medication: Yes ☐ No ☐
Any adverse reactions? Yes ☐ No ☐

Please list any non-psychiatric hospitalizations or surgeries you have had. ☐ N/A if none

Problem	Reason	Dates

Please list any allergies (Medication, seasonal, food, other): ☐ None ___________________________
Please explain. ____
Please discuss any relevant past medical histories (i.e., hysterectomy, cancer, strokes, heart attacks): ☐ N/A
____

For Women Only:
Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No

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Emergency Contact:

Name(s): ____
Phone: ____________________ Relationship: ____

In the event that I cannot contact you in an emergency, do I have your permission to contact the person you've named above? ☐ Yes ☐ No

Signature: ____ Date: ___________________________

Employment

Currently Employed? ☐ Yes ☐ No ☐ Full Time ☐ Part-Time ☐ Retired ☐ Disabled
What is your occupation: ____
Employer: ____ How long?____________________________
Current Employer Address:__________________________________ Phone: ______________________________
If you have been in your current job for 6 months or less, name your former employer, dates of employment, reason for leaving: ____

Do you enjoy your current job? ☐ Yes ☐ No What do you like/ dislike about your job? _____________________
If you're not currently employed, how long has it been since you last worked? (Months/Years)________________
What led to becoming unemployed? ____

Military History

☐ Currently on active duty ☐ Retired ☐ Never served How long did you serve in the military? ____________
If you have served in the military, were you ever deployed? ☐ Yes ☐ No
If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment: ☐ N/A ____
Type of Discharge: ☐ Honorable ☐ Dishonorable ☐ Medical ☐ Other

Education

Are you currently in school? ☐ No ☐ Yes ☐ Full time ☐ Part time
Name of Current School: ____Phone: _______________
Highest level of education: _____________ Degrees earned: _______________________________________
Vocational school/skill area: ____
College/Graduation school - Years completed/Major: ___________________________
Disciplinary actions, alternative schools, suspensions: __________________ or ☐ N/A

Ethnicity /Race

☐ Asian/American ☐ Latino/Latino American/Hispanic ☐ African American ☐ Middle Eastern
☐ White/Caucasian ☐ Unwilling to be identified by race ☐ Other: ___________________________________

Nationality

☐US Citizen ☐ Canadian Citizen ☐ Mexican Citizen ☐ Other:_______________________________________

Client resides in the United States as a: ☐ Citizen ☐ With a Student Visa ☐ Work Permit ☐ Other:____________

Language/Special Needs

Language: ☐ English ☐ Spanish ☐ Chinese ☐ Other:____
Limited English proficiency ☐ Yes ☐ No Interpreter needed? ☐ Yes ☐ No Language to be spoken in therapy? ___
☐ Deaf/Hard of hearing – Uses ASL ☐ Deaf/Hard of hearing – does not communicate using ASL
☐ Physically challenged (i.e., wheelchair, visual, etc.). Please specify: ___________________________ ☐ N/A
☐ Access issues (i.e., transportation, hours, etc.) Please specify: ___________________________________ ☐ N/A
☐ Specific assistance needed to participate in therapy: ____ ☐ N/A

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Cultural Diversity/Relevance

There may be cultural considerations, as well as a client's background or sexual orientation, which may be beneficial to discuss as we begin the therapeutic process. Please consider the following and mark any areas of concern you may have and feel it would be beneficial for us to discuss and consider as we go forward in treatment.

◻ Ethnicity ◻ Age ◻ Gender ◻ Sexual orientation ◻ Educational issues ◻ Socioeconomic concerns
◻ National origin ◻ Other: ____
Culture you most identify with: ____
Cultural issues you most identify with: ____
Describe any cultural issues contributing to current problems and/ or should be taken into consideration during treatment planning: ____
Any problems/issues you may have encountered because of your cultural background? ◻ Yes ◻ No
If yes, please explain: ____

Guardianship Information

If client is a minor, please complete the following:
Parent 1 Name: ____◻ Legal ◻ Joint ◻ Physical Custody
Parent 1 address: ____ Parent 1 Phone: ________________
Parent 2 Name: ____◻ Legal ◻ Joint ◻ Physical Custody
Parent 2 address: ____Parent 2 Phone: ________________
If there is shared custody, what is the timeshare arrangement? ___________________________________
Custodial parent information: ____
Legal Guardian (if different than parents) Name(s): ______________________________________
Address: ____ Phone: ____________________
Relationship: ____
Is there a conservatorship? ◻ Yes ◻ No If yes, please explain: ____________________________
Is there a need for a legal guardian or conservatorship that has not been met? ◻ N/A ◻ Yes ◻ No
If yes, please explain: ____

Insurance Information

Indicate how you intend to pay for treatment: ◻ Cash ◻ Check ◻ Credit card ◻ EAP. ◻ Insurance ◻ Third-party
Name of primary insured: ___________________________DOB: ______________ Employer: ______________
If primary insured is not you, give DOB: _________________ Employer: ________________________
If someone other than you is paying for this treatment, what is their name: _________________________
Your relationship: ______________________________ Phone:_________________________________
If necessary, may I contact this person regarding billing issues? ◻ Yes ◻ No

Signature:____ **Date:**_________________________

Biosocial Assessment – Part II

Nutritional Screening

Please check all that apply:
Follows special diet? ◻ Yes ◻ No If yes, please explain: _____________________________________
◻ Medications affecting nutritional status ◻ Weight gain/loss of 10 pounds or more without specific diet
◻ Change in appetite ◻ Binging ◻ Purging ◻ Use of laxatives ◻ Intense focus on weight, body size, calorie intake, exercise ◻ Other:____
◻ Food Allergies ◻ Eating a balanced diet by the food pyramid standard most of the time
On a scale of 1-10, 10 being very satisfied, how satisfied are you with your body image? ______________________

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Social Support Systems

Supportive Social Network? (Rate the network using a scale of **1 Weak to 5 Strong**)

Parents	**Work**
Siblings	**Doctor**
Spouse/Partner	**Pastor**
Children	**Community Service**
Extended Family	**Friends**
School	**Other**

Comment: ____

Current Living Situation

Please check all that apply:

□ Rent □ Own □ Friend's Home □ Relative's/Guardian's home □ Foster care home □ Homeless
□ Shelter □ Housing Overcrowded. □ Living Companion(s) dysfunctional □ Other:____________
Living at risk of losing current housing: □ Yes □ No Satisfied with current living situation: □ Yes □ No

Financial Situation

Presence or absence of financial difficulties: (Fields below are optional. Please check all that apply.)
□ No Current Problems □ Large Indebtedness □ Relationship Conflicts Over Finances □ Impulsive Spending
□ Poverty or Below □ Financial Difficulties □ Ever file Bankruptcy? □ Yes □ No If so, when? ___________

Source of Income:
□ Employment □ Unemployment □ Spouse/Significant Other □ Social Security □ Retirement
□ Short Term-Disability □ Other: ____

Family Counseling Interest

Describe any family members and your desire for their involvement in your treatment process: _________________
____
Perceived level of support for treatment? (**Scale 1-5, with 5 being the most supportive**) ______________________

Legal Status/History

Past, current, pending legal problems (Please select all that apply.)
□ None □ Gangs □ DUI/DWI □ Arrests □ Conviction □ Detention □ Jail □ Probation □ Other: _____________
If yes to any of the above, please explain: ____
Any court-ordered treatment? □ Yes □ No If yes, please explain: _________________________________
____
Offense(s): ____

Religion

□ Catholic □ Protestant: □ Jewish □ Mormon □ Buddhist □ Muslim □ Spiritual but not religious
□ Other: ____
How important is religion to you/your family? □ Not important □ Somewhat Important □ Very Important
Does your faith help you to cope with life's problems? □ Yes □ No
If so, please describe: ____

Leisure and Recreation

Which of the following applies to you:
□ Spend time with friends □ Sports/Exercise □ Time with Family □ Hobbies □ Watch Movies/T.V.
□ Stay at Home □ Listen to Music □ Spend Time at Clubs/Bars □ Other: ____________________

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What limits the client's leisure/recreational activities?____________________________________

Social Relationships

How frequently do you socialize with friends? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
How frequently do you socialize with extended family? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
What kinds of activities do you do when you get together? ____________________________________

On a scale of 1-10, 10 being very satisfied:
Rate your satisfaction with peer relationships: ________ Rate extended family relationships: _________
Who do you feel is "on your side" in life? ____
Are there any people in your life you can talk to about your problems?____________________________
Please describe any difficulties you are having socially: ______________________________________
How do you describe your friendship: ☐ No Friends ☐ Only Acquaintances ☐ Acquaintances & Friends
Number of close friends: ___________

Support Network

From whom or where do you get your support? Select all that apply. (Use back of page if needed.)
☐ Supportive Family ☐ Supportive Partner ☐ Religious/Spiritual Organizations ☐ Work/Social Groups
☐ Other(s): ________________ Describe any difficulties you are having socially: ___________________________

Sexual History (Optional)

How did you learn about sex? ____
How old where you when you first had sex? ____
Were you using alcohol or drugs during your first sexual experience? _______________________
How has alcohol or drug use affected your sex life? _____________________________________
Describe any current or past sexual concerns: ____
How satisfied are you with your sex life? ☐ N/A (From 1-10, 10 being great) ________________

Functional Assessment-General

Is Client able to care for him/herself? ☐ Yes ☐ No If no, please explain: ________________________________
Uses or needs of adaptive devices (select all that apply:) ☐ None ☐ Glasses ☐ Walker ☐ Braille
☐ Hearing Aids ☐ Cane ☐Crutches ☐ Wheelchair ☐ Translated Written Information ☐ Translator for Speaking
☐ Other: _____________Does the client have a history of falls? ☐ Yes ☐ No Please explain: __________________

New/Old Stressors

Do you feel excessively stressed? ☐ Yes ☐ No
What is the source(s) of your stress? ☐ Relationship ☐ Family ☐ Job ☐ Housing ☐ Financial ☐ Legal ☐ Illness
☐ Deaths ☐ Abandonments ☐ Traumatic Incidents Other(s): ____________________________________
Do any religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? ☐N/A
If so, please describe: ____
Do you have specific methods of reducing your stress? ☐ Yes ☐ No Describe: ____________________________
Would you like to discuss additional ways of reducing your stress?: ☐ Yes ☐ No
Describe how your stress is impairing the quality of your life: ____

Dependent Care Issues:

Number of Dependent Adults: ______________________ Ages: __________________________________☐ N/A
Number of Dependent Children: _________________________ ☐ N/A Ages of Children: __________________
Needs/ Special Needs: ☐ Yes ☐ No If yes, please explain: ____
Behavior Problems ☐ Yes ☐ No ☐ Child Support Please explain:____

Sleep

Are you having any troubles with your sleep? ☐ Yes ☐ No
If yes, check where applicable: ☐Sleeping too much ☐ Sleeping too little ☐ Poor quality of sleep
☐ Disturbing dreams ☐ Other (please describe) ____
☐ Do you take medication to help you sleep? ☐ Yes ☐ No
Name of Medication: ______________________________Prescribing Dr.:_________________________________
Do you need/would you like to improve your current sleep patterns? ☐ Yes ☐ No

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Over the counter sleep medication? □ Yes □ No   Name of medication: _______________________________

Exercise

Your Exercise Level (1 being beginner, 5 being highly athletic): _____
Do you exercise regularly? □ Yes □ No
How many days/times per week do you exercise? __________
What types of exercise do you do? ____

Hobbies

Do you have activities/hobbies you do regularly for enjoyment? □ Yes □ No
Do you need/would you like to participate in more enjoyable activities in order to experience increased enjoyment?
□ Yes □ No
Explain: ____
□ Currently participate in spiritual activities? □ Yes □ No
If answered "yes" to any of above, describe: ____

Signature:____ **Date:**_____________________

Signature:____ **Date:**_____________________

Diagnosis: