

Biosocial Assessment Part 1

Provider Information

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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: _____

NAME _____ DATE _____

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 NoCell phone: None () _____ Okay to call/leave message? Yes NoWork phone: None () _____ Okay to call/leave message? Yes NoWhich phone number do you prefer I use to contact you? Home Work CellRelationship 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:

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?

NAME _____ DATE _____

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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 medication						
Opioids/Narcotics						
Amphetamines						
Cocaine						
Heroin						
Meth						
Others						

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

NAME _____ DATE _____

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

NAME _____ DATE _____

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 NoIf 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

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? _____

NAME _____ DATE _____

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 ImportantDoes 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: _____

NAME _____ DATE _____

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

Social RelationshipsHow frequently do you socialize with friends? Frequently Sometimes Rarely NeverHow 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 were 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 NoWhat 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/ANumber 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 NoIf 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

NAME _____ DATE _____

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: