New Patient and Biopsychosocial History Form | Kimberly Skelton, LPC, LCAS

Today's Date:______________/_______/_______________

DEMOGRAPHICS

Name:____Soc Sec #:_________-_________-____________

Sex/Gender:____________ Race: _________________Marital Status:__________________ Birth Date: ______/______/_____________

Employment:__________________________Height:_________ Weight:_______Hair Color: ______________ Eye Color: _____________

Spiritual Background/Religion:_____________________________________Sexual Orientation:_________________________________

Address:____ City:__________________ State:_________ Zip:___________________

CONTACT INFORMATION PREFERNCES

Home phone #: _________________________________Approval to leave voicemail?__________________

Cell phone #: ___________________________________Approval to leave voicemail?__________________ Text?________________

Email address:____________________________________Approval to send email?_____________________

Primary Physician and contact information:____

Emergency Contact Name and phone number:____

Insurance Carrier: _______________________Subscriber Name:________________________Relationship to you:_________________

Subscriber ID:___________________________Group #:_______________________________Date Issued:____/______/_____________

How did you hear about my counseling practice?____

FAMILY BACKGROUND

Current living arrangement: ____You were raised by:_______________________________

Family members you are close to now:____

Children and their ages:____

Describe your relationship with your parental figures while growing up:____

If alive, describe them currently:____

Please list any siblings, their ages and describe your current relationship with them:____

____

Briefly describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse/mental health: ____

Sexual/physical/emotional abuse:____

MARITAL/SIGNIFICANT PARTNERSHIP HISTORY

Marital status: ___Single/never married ___Married ___Partnered ___Separated ___Divorced ___Widowed ___Living with someone

If currently married/partnered, when were you married/partnered? _____________ If living w/someone, how long? ______________

Describe your current relationship with your significant other:____

EDUCATION

Last grade or degree completed:____________________________________ Have a learning difficulty? If yes, specify:_____________

Desire to continue education? _____Yes _____No In school now?_____________If so, where?______________________________

EMPLOYMENT

Employer:____Years on job:________________________________

If no job, when and where did you last work?________________________________Looking for work now? _____Yes _____No

Any job problems now? _____Yes _____No Explain:____

Ever been fired? _____Yes _____No How many times:___________Reason:____

Special Abilities or Competencies? _____Yes _____No Describe:____

LEGAL HISTORY

Arrest Date	Charge	Convicted?	Sentence

Are you currently on Probation or Parole? _____Yes _____No Ending Date:___________________________

Are you involved in any lawsuits or have any upcoming Court dates? _____Yes _____No When?____________________

MILITARY SERVICE ____N/A

Type:______________________________When:__________________________ Honorable discharge? _____Yes _____No

If not, why?___________________________________ Describe any combat experience:____

Are you troubled now by your experience in the military? _____Yes _____No

INTERESTS/ACTIVITIES/SUPPORTS/STRENGTHS

What are your interests and activities?____

Do you feel you spend enough time on your interests or non-work activity? _____Yes _____No

Do you have adequate supports in your life? _____Yes _____No Who?____

What do you consider your strengths? ____

MEDICAL HISTORY

How is your general health? ___Excellent ___Good ___Fair ___Poor

Any significant illnesses, injuries or major medical issues? ___Yes ___No Describe:______________________________________

Current Medications Taken (List All):

Name Dosage Reason Prescribed and Date

____

____

____

FOR WOMEN

Number of pregnancies?_______Live births:________Adoptions:________Normal menstrual cycle? _____________
Are you pregnant?________Premenstrual syndrome?_________Menopause?________Hormone therapy?________

MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING AND TREATMENT HISTORY

Please circle any of the following that apply to you now or within the past month (feel free to explain):

Depression Increased alcohol use Nervous/Anxious

Crying spells	Increased drug usage	Panic attacks
Hopelessness	Blackouts/memory loss	Can't concentrate
Relationship breakup	Withdrawal symptoms	Confusion
Loneliness	Financial worries	Mood swings
Emptiness	Loss of control in:	Racing thoughts
Loss of appetite	- alcohol/drug use	Fear of dying
Sleep disturbance	- overeating/bingeing	Job stress
Nightmares	- purging	Decreased activity
Thoughts of harming self	- yelling/breaking	Not seeing friends
Thoughts of harming others	- hitting people	Feel controlled
Suicide attempts/injuries	- endangering self	Feel talked about
Hearing voices	- endangering others	Guilt/shame
Seeing things others don't	- spending	Sexual problems
Unusual thoughts	- gambling	School problems

TREATMENT HISTORY

Types of Treatment Experiences	Total # of times	Date of Most Recent Time or Session	Location	Outcome
Medical Hospitalization (surgeries, etc)		_____/_____/________		
Hospital Detox or Inpatient or Outpatient (circle) Alcohol/Drug Treatment		_____/_____/________		
Inpatient or Outpatient (circle) Mental Health Treatment		_____/_____/________		
AA/12 Step Meetings/ Support Groups		_____/_____/________		

Have you ever attempted suicide or seriously harmed yourself? When?________________Describe:___________________________

Has anyone in your family attempted suicide?__________Completed suicide?___________Who/When?________________________

Have you ever attempted to kill or seriously harm someone else? ________Who and when?__________________________________

Describe:____

Have you ever been the victim of physical, sexual or verbal abuse? Any other trauma?_____________________________________

Describe: ____

Have any family members had a history of mental illness or addiction? ___Yes ___No If so, describe illness (give diagnosis if known):____

Family History of Criminal Activity or Violent Behavior?____

Family History of Medical Problems?____

ALCOHOL AND SUBSTANCE HISTORY: Please fill in the chart according to your past substance usage.

TYPE OF DRUG If certain type, please circle. Ex: cigarettes under nicotine or beer under alcohol	AGE OF 1ST USE	WHAT AGE WERE YOU USING IT REGULARLY	AVERAGE # OF DAYS USED EACH WEEK	AVERAGE AMOUNT USED DAILY	# DAYS USED IN PAST 30 DAYS	DATE LAST USED
Tobacco						
Nicotine (Cigarettes, Dip, Cigars, etc.)						
Alcohol						
Alcohol (beer/wine/liquor/moonshine)						
Cannabinoids						
Marijuana/Hashish						

Opioids						
Heroin (IV?__________)						
Opium						
Opioid Pain Pills Types_________________________						
Stimulants						
Cocaine						
Amphetamine (diet pills, ADHD meds such as Adderall, Ritalin, Concerta)						
Methamphetamine						
Benzodiazepines						
Ex: Xanax, Klonopin, Ativan Types_________________________						
Club Drugs						
GHB						
MDMA (Ecstasy or Molly)						
Rohypnol						
Dissociative						
Ketamine						
PCP and analongs						
Salvia Divinorum						
Dextromethorphan (DXM)						
Hallucinogens						
LSD						
Mescaline						
Psilocybin (mushrooms)						
Other Compounds						
Anabolic steroids						
Inhalants						
Other:____________________						

Have alcohol and/or drugs ever caused problems in any of the following areas? family _______ employment ________ legal ________ emotional ________ social _______ financial ________ behavior ________ physical ________

Does a relative, loved one, friend, court or employer think so? ___Yes ___No Explain:_______________________________________

Are there other things not covered that you would like your mental health provider to know?_________________________________

____

What are your hopes for treatment?____

____

____

Diagnosis(es)/Needs/Assessment Summary and Plan:

Client's Signature:____ Date:________________________________

Clinician's Signature:____ Date: ________________________________