

Your Company Name

Your Company Address

Biopsychosocial Assessment

The purpose of this mental health program/service is to assist clients on reducing behavioral symptoms and health risks and gaining a more stable mental health.

Program: CMH PRIV	Date:	Setting:	Select: <input type="checkbox"/> BIO H0031 HN <input type="checkbox"/> GT <input type="checkbox"/> IDA <input type="checkbox"/> H0031 <input type="checkbox"/> HC <input type="checkbox"/> GT
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1. DEMOGRAPHIC DATA

Client Name:	Case No.:	DOB:
Referral Source:	Legal Guardian: N/A	Legal Guardian Phone: N/A
Emergency Contact: N/A	Relationship: N/A	Phone: N/A

2. PRESENTING PROBLEM(S): (list specific symptoms, criteria for diagnosis and justification of treatment recommendations)

CLIENT'S ASSESSMENT OF SITUATION: (list how the client's symptoms are affecting clients emotional functioning, use their own words)

BEHAVIORAL OBSERVATIONS - PRESENTATION (Check all that apply & specify additional details when needed):

General Appearance	<input type="checkbox"/> Good/Well-Kept <input type="checkbox"/> Appear Stated Age/Older/Younger	<input type="checkbox"/> Appropriate <input type="checkbox"/> Height/Weight	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Not appropriate for setting	
Ambulation	<input type="checkbox"/> WNL <input type="checkbox"/> Antalgic gait	<input type="checkbox"/> Unsteady <input type="checkbox"/> Assistive Device	<input type="checkbox"/> Cane/Wheelchair/Walker <input type="checkbox"/> Assistive Device		
Motor Activity	<input type="checkbox"/> WNL <input type="checkbox"/> Hiperactive	<input type="checkbox"/> Retarded <input type="checkbox"/> Slow	<input type="checkbox"/> Accelerated <input type="checkbox"/> Restless	<input type="checkbox"/> Stupors <input type="checkbox"/> Tremors/Shakes	<input type="checkbox"/> Ticks
Eye Contact	<input type="checkbox"/> WNL	<input type="checkbox"/> Poor	<input type="checkbox"/> Variable	<input type="checkbox"/> Eyeglasses (for seeing/shades)	
Hearing	<input type="checkbox"/> WNL	<input type="checkbox"/> Poor	<input type="checkbox"/> Hearing Aides		
Speech - Pitch & Tone	<input type="checkbox"/> WNL	<input type="checkbox"/> Hight	<input type="checkbox"/> Low	<input type="checkbox"/> Unusual	<input type="checkbox"/> Monotone
Speech Content & Production	<input type="checkbox"/> WNL <input type="checkbox"/> Clanging <input type="checkbox"/> Impediments <input type="checkbox"/> Tangential <input type="checkbox"/> Dysarthric	<input type="checkbox"/> Slowed <input type="checkbox"/> Presure <input type="checkbox"/> Limited <input type="checkbox"/> Stutters	<input type="checkbox"/> Slurred <input type="checkbox"/> Sparce <input type="checkbox"/> Aphasic <input type="checkbox"/> Echolalia	<input type="checkbox"/> Over Production <input type="checkbox"/> Other <input type="checkbox"/> Organized <input type="checkbox"/> Other	
Hand Dominance	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Ambidextrous		
Behavior & Attitude	<input type="checkbox"/> Cooperative <input type="checkbox"/> Withdrawn <input type="checkbox"/> Agitated	<input type="checkbox"/> Guarded <input type="checkbox"/> Hostile <input type="checkbox"/> Disruptive	<input type="checkbox"/> Belligerent <input type="checkbox"/> Combative <input type="checkbox"/> Oppositional	<input type="checkbox"/> Dramatic <input type="checkbox"/> Manipulative	
Rapport w/Clinician	<input type="checkbox"/> Established	<input type="checkbox"/> Not Established	<input type="checkbox"/> Difficult to Establish		
Effort	<input type="checkbox"/> WNL	<input type="checkbox"/> Minimal	<input type="checkbox"/> Need a lot of reinforcement & prompting		
Responses	<input type="checkbox"/> Frank	<input type="checkbox"/> Over-exaggeration of symptoms <input type="checkbox"/> Minimize Symptoms			<input type="checkbox"/> Inconsistent/Dishonest

BEHAVIORAL OBSERVATIONS - EMOTIONS (Check all that apply & specify additional detail when needed):

Mood	<input type="checkbox"/> Content <input type="checkbox"/> Angry <input type="checkbox"/> Variable	<input type="checkbox"/> Euphoric <input type="checkbox"/> Confused <input type="checkbox"/> Distrustful	<input type="checkbox"/> Apathetic <input type="checkbox"/> Irritable <input type="checkbox"/> Optimistic	<input type="checkbox"/> Depressed/Sad/Dysthymic <input type="checkbox"/> Anxious/Fearful/Worried <input type="checkbox"/> Neutral
Affect	<input type="checkbox"/> Labile <input type="checkbox"/> Flat	<input type="checkbox"/> Constricted <input type="checkbox"/> Depressed	<input type="checkbox"/> Blunted <input type="checkbox"/> Tearfulness	<input type="checkbox"/> Appropriate/Inappropriate Range <input type="checkbox"/> Congruent/Incongruent to Mood
Suicide: Current/Past	<input type="checkbox"/> None	<input type="checkbox"/> Ideations	<input type="checkbox"/> Plans/Threat	<input type="checkbox"/> Attempts <input type="checkbox"/> Self-Injury
Homicide: Current/Past	<input type="checkbox"/> None	<input type="checkbox"/> Ideations	<input type="checkbox"/> Plans/Threat	<input type="checkbox"/> Attempts <input type="checkbox"/> Cause Injury
Depressed Symptoms - Cause	<input type="checkbox"/> Sadness <input type="checkbox"/> Withdrawn <input type="checkbox"/> Mania	<input type="checkbox"/> Helplessness <input type="checkbox"/> Anhedonia <input type="checkbox"/> Mood Swing	<input type="checkbox"/> Hopelessness <input type="checkbox"/> Low Self-esteem <input type="checkbox"/> Low Self-worth	<input type="checkbox"/> Depressed mood <input type="checkbox"/> Anger/Aggression <input type="checkbox"/> Low motivation
Anxiety Symptoms - Cause	<input type="checkbox"/> Worries <input type="checkbox"/> Fears	<input type="checkbox"/> Anxious <input type="checkbox"/> Irritable	<input type="checkbox"/> Panic Attack	<input type="checkbox"/> Easily Stressed
Eating Habit	<input type="checkbox"/> WNL	<input type="checkbox"/> Poor Nutrition	<input type="checkbox"/> Increased Appetite	<input type="checkbox"/> Decreased Appetite
Sleep	<input type="checkbox"/> WNL <input type="checkbox"/> Nightmares/Night Terrors	<input type="checkbox"/> Increased sleep <input type="checkbox"/> Early morning awakening	<input type="checkbox"/> Decreased sleep <input type="checkbox"/> Restless sleep	<input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty Staying Asleep

BEHAVIORAL OBSERVATIONS - COGNITION (Check all that apply & specify additional details when needed):

Attention Span	<input type="checkbox"/> Sustain attention/Focus	<input type="checkbox"/> Easily distracted/lacked focus	<input type="checkbox"/> Inattentive/Shortened	
Intelligence	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Significantly Low
Insight	<input type="checkbox"/> WNL	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Superficial <input type="checkbox"/> Limited
Judgment	<input type="checkbox"/> WNL	<input type="checkbox"/> Poor	<input type="checkbox"/> Impaired	<input type="checkbox"/> Limited
Impulse Control	<input type="checkbox"/> WNL	<input type="checkbox"/> Poor	<input type="checkbox"/> Explosive	<input type="checkbox"/> Impulsive <input type="checkbox"/> Low Impulse
Thought Content & Process	<input type="checkbox"/> Logical <input type="checkbox"/> Concrete <input type="checkbox"/> Tangential	<input type="checkbox"/> Goal Directed <input type="checkbox"/> Confused <input type="checkbox"/> Circumstantial	<input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Perseverance <input type="checkbox"/> Slow processing	<input type="checkbox"/> Loosening of association <input type="checkbox"/> Poor Comprehension <input type="checkbox"/> Abstraction Ability
Hallucination & Delusions	<input type="checkbox"/> None	<input type="checkbox"/> Type		
Orientation	<input type="checkbox"/> Alert <input type="checkbox"/> Situation <input type="checkbox"/> Person	<input type="checkbox"/> Place <input type="checkbox"/> Delirious	<input type="checkbox"/> Time (Day - Date - Month - Year - Time) <input type="checkbox"/> Disoriented	

FAMILY'S ASSESSMENT OF SITUATION: (if applicable, list how the client's symptoms are affecting clients emotional functioning and use family's own words)

N/A

FAMILY'S EMOTIONAL FUNCTIONING (Describe any emotional issues, difficulties functioning, substance abuse and/or abuse history affecting family members)

N/A

LEGAL REPRESENTATIVE'S ASSESSMENT OF SITUATION: (if applicable, in their own words)

N/A

3. BEHAVIORAL HEALTH HISTORY

Date of onset of mental illness. Document any serious behavior or physical illness, injuries, operations or hospitalizations and indicate the year these occurred (give special attention to previous behavioral health treatment and document contact information for coordination of care.)

Problems	Date

4. CURRENT MEDICATIONS

Psychotropic, Medical, and over the counter.

Medication	Dose	Frequency	Prescriber

5. BEHAVIORAL HEALTH ASSESSMENT

A. Does the client and/or family member have current or history of the following? (Check all that apply)
Orientated to:

<input type="checkbox"/> Place	<input type="checkbox"/> Delusion (specify)	<input type="checkbox"/> Recent appetite changes
<input type="checkbox"/> Person	<input type="checkbox"/> Inattention/Easily Distracted	<input type="checkbox"/> Sleep Disturbance (explain)
<input type="checkbox"/> Time	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Recent change in Weight
<input type="checkbox"/> Irritability	<input type="checkbox"/> Experienced traumatic event	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Aggressive/Angry Behavior	<input type="checkbox"/> Panic attack	<input type="checkbox"/> Drinking Alcohol
<input type="checkbox"/> Impulsive/Risky Behavior	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Taking drugs
<input type="checkbox"/> Non-Compliant	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Fear/Phobias
<input type="checkbox"/> Auditory/Visual Hallucinations	<input type="checkbox"/> Suicidal Thinking	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Social Problems	<input type="checkbox"/> Other	

B. Suicide/Homicide Risk Mini Screening: (if any of the following questions are answered “yes” please complete the SBQ-R with client and follow precautionary procedures)

Client and family deny any current suicidal/homicidal ideations (if denied, skip to section 6)

Have you ever thought about killing yourself or others? If yes, explain:	<input type="checkbox"/>
Do you own a weapon? If yes, explain:	<input type="checkbox"/>
Does client have a plan or access to plan or individual?	<input type="checkbox"/>
Have you ever been hospitalized for depressive symptoms? If yes, detail:	<input type="checkbox"/>
Have the client received another behavioral health service in the last 2 years? If yes, specify:	<input type="checkbox"/>

B. Physical/Sexual/Emotional Abuse: (current and history - if indicated, record the name of perpetrator, time, dates, and whether reported.)

If any abuse is indicated in the process, you must do the following:

1. Call the abuse hotline 1-800-962-2873 or 800-96-ABUSE in all case, If not previously reported (you don't have to file a duplicate report of the abuse if the client/family can provide written proof that it was reported, DCF documentation, DCF Case worker information, Termination of parental rights.)
2. Discuss the client with your supervisor.

Date of incident:

Person:

Client and family deny any abuse or trauma history (physical, sexual, emotional abuse, exploitation and neglect.)

Approximate date of client:

Approximate date of report was:

Filed Relationship of the abuser of client:

Details of incident:

Outcomes of abuse:

Report:

A referral for assessment/services indicated

When:

Where:

Obtain release of information for collaboration of care.

Where records of previous treatment requested? If requested, when?

6. PHYSICAL HEALTH ASSESSMENT

Has the client visited a physician in the last one years? Yes No

(If no, provide client with education on preventative health measures and offer to refer to a physician)

If yes, give reason and date: Follow up visit:

Name of Primary Care Physician:

Phone Number:

Address:

Is the client experiencing any pain? Yes No

If yes, specify where?

For how long (including frequency of pain)?

Please rate pain from 1 (no pain) to 10 (intense pain):

Has client been treated for pain?: Yes No

Please include services that client is receiving for pain (if any). If not, describe referral to PCP/Specialist for able to manage and follow up.

Does client require a referral? If referral, where?

Obtain release of information so care can be collaborated.

6. Nutritional Risk Assessment:

Direction: Indicate with "yes" to assessment, then total score to determine additional risk.

Nutritional Score	
Has an illness or condition that changed the kind and/or amount of food eaten?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eats fewer than 2 meals per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eats few fruits, vegetables, or milk products.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have 3 or more drinks of beer, liquor, or wine almost every day.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have tooth or mouth problems that make it hard to eat.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does not always have enough money to buy the food needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eats alone most of the time.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Takes 3 or more different prescribed or over-the-counter drugs a day.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Without wanting to, has lost or gained 10 pounds in the last 3 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Not always physically able to shop, cook, and/or feed self.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total:	

0-2 **GOOD.** As appropriate reassess and/or provide information based on situation.

3-5 **MODERATE RISK.** Educate, refer, monitor, & reevaluate based on patient situation & organized policy.

6 > **HIGH RISK.** Coordinate with physician, dietician, social service professional or RN about how to improve nutritional health.

If 6 OR HIGHER, REFER TO _____ DATE: _____

NUTRITIONAL STATUS		
Appetite	Hydration	Recent Weight Change
<input type="checkbox"/> Diminished <input type="checkbox"/> Increased <input type="checkbox"/> WNL <input type="checkbox"/> Anorexia	<input type="checkbox"/> Diminished <input type="checkbox"/> Increased fluid <input type="checkbox"/> Restricted Fluids <input type="checkbox"/> WNL <input type="checkbox"/> Inadequate	<input type="checkbox"/> Intended <input type="checkbox"/> Unintended <input type="checkbox"/> Gain <input type="checkbox"/> No Change

7. PSYCHOSOCIAL HISTORY

Substance abuse (for client and family members, list types of substances, duration of use and any treatment receive):

Legal history (specifying changes, date, convictions, and incarcerations):

Personal family Psychiatric History (for client and family members, list types of diagnosis, types of services, duration of use and any treatment received):

- Does client require a referral? If referred, where? _____
- Obtain release of information so care can be collaborated.

8. BACKGROUND, SOCIAL, AND EDUCATION

Place of Birth: _____ if foreign-Born, age/date of arrival to US: _____
Primary location where client was raised: _____

General description of childhood/adolescent/ adult experience:

Current experience: (include leisure activities and interest)

What are the client's/family's belief and important spiritual practices? (Include how these beliefs assist client in dealing with stressors)

9. FAMILY EXPERIANCE

Relationship with family, friends, romantic interests:

Number of children (specify gender and current age)

Marital Status:

Single Married Separated Divorced Widowed Cohabiting

- If married or cohabiting, how long: _____
- If separated, divorced, or widowed, how long: _____
- If sexually active, is client aware of risks regarding Sexually Transmitted Diseases: Yes No
- If "No", please educate client as to risk of Sexually Transmitted Diseases.

10. EDUCATIONAL ASSESSMENT

Is geared towards indicating whether a patient needs educational services in addition to therapeutic interventions. (Please provide goal for educational services if applicable and/or if unviable, refer client to a community provider.)

1. Do you have any religious/cultural practice that may hinder your educational goals? Yes No
2. What is your language of preference:
3. Do you have any visual, hearing or other sensory impairing that may affect your ability to learn?
Yes No
4. Highest educational level:
5. Do you have any physical limitations that may hinder your ability to learn? Yes No
6. Can client follow/understand directions (ask client to print name and sign master (Treatment Plan)
Yes No

11. IF COMPLETING AS IN-DEPTH ASSESSMENT

Provide integrated summary below: (include and integrate clients identified as high risk, past intensive services received, justify client's need for services with need of a higher level of care; and from children age range 0-5 explain the symptoms exhibited that are atypical to child's development.)

12. TREATMENT NEEDS

13. DIAGNOSIS IMPRESSION

Code:

Code:

Treatment Recommendation:

14. SIGNATURES

Unlicensed Clinical

This Unlicensed Clinical has completed a face to face interview with the client and has made appropriate treatment recommendations based on such interaction (Qualified Licensed Supervisor review and signature documented showing concurrence with diagnosis and treatment.

Unlicensed Practitioner Signature

Unlicensed Practitioner Names

Date

Licensed Clinical

This Unlicensed Clinical has completed a face to face interview with the client and has made appropriate treatment recommendations based on such interaction (Qualified Licensed Supervisor review and signature documented showing concurrence with diagnosis and treatment.

Licensed Practitioner Signature

Licensed Practitioner Names

Date

- I concur with the diagnosis and treatment recommendations.
- I do not concur with the diagnosis and treatment recommendations. Alternative diagnosis and/or recommendations

Clinical Director Signatures

Clinical Director Names

Date