Apex Therapeutic Services, PLLC
Healing Mind, Body & Spirit
3220 Henderson Drive * Jacksonville, NC 28546 * 910-238-4348* apexstaff@yahoo.com
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ADULT Comprehensive BioPsychoSocial History Interview& Diagnostic Assessment/Evaluation

Updated 2/25/16

The following Client information will be used to facilitate treatment planning and process. It may also be used to support/formulate the assignment of a DSM-V diagnosis. Please complete the information and place in Client's file. The information should be gathered before a formal assessment is completed but can also be used to develop a treatment plan and throughout the treatment process.

Client Name: ____
DOB: __________
Counselor Conducting Interview/Title: _____________________________________
Date of Interview: __________

Demographics
Age: _______ Race: ___________________
Legal Guardian: Self Parent Other: ________________________________
Military: Y N Branch: ________________
Current Living Situation:
Homeless Private Residence Facility Shelter Temporary Other:________
Please list those currently living in your household: (Name, age, relationship)

1. ____
2. ____
3. ____
4. ____

Do you know: DAY ______ TIME ______ YEAR ______

REASON for this assessment. Presenting Issues/ Symptoms/Complaints:
WHY ARE YOU HERE?
____
____
____
Voluntary Involuntary Referral
Accompanied by: Self Other: ____

(Counselor) Short Term Memory: BALL ORANGE CAR

Family of Origin History
Are you adopted: Y N Details: ____
Where were you born? ____
How many times did you move as a child? ________________________
Mother's name: _____________________________ Age: _____ / Deceased: _________
Occupation: _______________ Health ___________________
Where does she live now? _________________________________
Your current relationship w/Mom: None Good Bad Rocky Other: _____________

Your childhood relationship w/ Mom: None Good Bad Rocky Other: ____________

Father's name: ___________________________ Age: _____ / Deceased: _________
Occupation: _______________ Health ___________________
Where does he live now? _________________________________
Your current relationship w/Dad: None Good Bad Rocky Other: ___________
Your childhood relationship w/Dad: None Good Bad Rocky Other: ___________
Are your parents married? Y N If divorced/separated, how old were you when they divorced? ________________ Why did they divorce/separate?__________________
Who did you grow up with? ____
Did either of your parents remarry? Y N, if so ho/when: ________________________
Siblings: Brothers/Sisters, ages
____
____
____
Your relationship/s with sibling/s now: None Good Bad Rocky
Other: ____
Your relationship/s with sibling/s during childhood: None Good Bad Rocky
Other: ____

Growing up, did you experience or witness any of the following in your home:

Domestic violence	Neglect	Physical Abuse	Poverty
Sexual Abuse	Verbal Abuse	Infidelity	Adoption
Substance Abuse	Loss of Family Member	Mental Illness	
Divorce	Natural Disaster	Military Life/Deployments	
Medical Issues	DSS involvement	Homelessness	

Other/Explain:____
____
Did your family practice religion? Y N Details: _____________________________________

<u>Cultural/Spiritual/Recreational History:</u>
Cultural Identity (ethnicity, religion): ____
Describe any cultural issues that contribute to current problem(s): ________________________
____
Currently active in community/recreational activities? Y N
Formerly active in community/recreational activities? Y N
Currently engage in hobbies? Y N
Currently participate in spiritual activities? Y N
If answered "yes" to any of the above, describe: _______________________________________
____
____

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Developmental History

Were you healthy at birth? Y N DK ____
Disabilities: None Cognitive MR Hearing Speech Sight Mobility
Did you have any developmental delays or issues? Y N
Explain: ____
Were there any significant events or problems? Y N Details: ______________________
____
How were you disciplined? ____
Did you consider it appropriate or abusive? _______________________________________
Did you have behavior problems growing up? Explain ______________________________
____
Did you receive counseling as a child: Y N
For: ____
Were you emancipated from your home? Y N At what age? ___
Circumstances: ____
Did you witness or experience any traumatic events during your childhood? What?
____

Did you experience prenatal exposure to: Alcohol Tobacco Other drugs None DK

Educational History

HS Diploma	GED	Highest Grade Completed: ____________
College degree	Graduate degree	Technical/ trade school
Current Student	Dropped Out	Illiterate

At what age did you begin school? ______________
Did you like school? Y N
Did any of the following apply to you? Y N
Advanced/Gifted Classes Behavior Classes Special Education
Learning Disorder Attention Disorder Speech Disorder Other: ______________
How did you perform in school? Good Average Poorly Other: __________________

Sports/Extracurricular activities: Y N ____
Did you work while in high school? What did you do?_________________________
Did you date in high school? Y N
Did you use alcohol and how much? Y N _______________________________________
Did you use drugs? What did you use? Y N ____________________________________
Were you ever suspended/expelled? Y N_______________________________________
Were you ever arrested? Y N Explain: ____
How did you get along with your teachers? ______________________________________
How did you get along with your peers? ____

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Vocational/Military History:

Career Field or Usual field of employment: ___________________________________

Currently:

Employment Status: ____

How long have you been at your current or most recent job? ______________________

Describe your current job satisfaction:

NA Very Dissatisfied Mildly Dissatisfied Neutral Satisfied Very Satisfied

Are you disabled? Y N Nature of Disability: _____________________________

Social Security Disability SSI Pending Denied Are you your own payee? Y N

Military Service

None Veteran Active Duty Disabled Current/ Former Spouse/ Dependent

Officer Enlisted Warrant Officer Retired Branch: ________________________

Highest Rank: ___________ Current Duty Station: ____________________________

Enlistment Date: ________________ Discharge Date: ___________

Family history of military service:

Y N: ____

Do/did you like being in the military? Y N

____

Disciplinary Actions? Y N ____

____

Deployments/where/when?____

____

Significant Experiences: ____

____

If you deployed, have you experienced any of the following symptoms since returning? Y N

If so, circle which ones:

-Nightmares -Reliving events - Intrusive thoughts

-Becoming upset when exposed to reminders

-Efforts to avoid thoughts/ feelings or conversations about events

-Avoiding physical reminders - Inability to recall aspects of the event

-Diminished interest in previously enjoyed activities

-Diminished energy -Feeling estranged or detached

-Sense of foreshortened future -Difficulty falling or staying asleep

- Irritability - Outbursts of anger -Difficulty concentrating

- Super aware of your surroundings -Physical signs

-Other changes: ____

Have you been evaluated for PTSD or combat stress? Y N

Details: ____

Are you experiencing other changes or effects that you attribute directly to deployment? Y N

Details: ____

Social/Marital History **NA**

#Marriages_____ #Divorces_____ Single Single-Parent

Sexual Orientation: ____________

Are you currently/actively married? Y N

Date of Marriage: _________________ Date of Divorce: _____________________

If yes, Spouse's name: ___________________ Age ______

How long have you know each other? ____

How did you meet? ____

Spouse's employment: ____

Does your spouse reside with you? Y N:

If not, where: ____

Status of the relationship now? ____

Significant marital/relationship issues:

Domestic Violence	Arguing	Sexual Problems	Substance Abuse
Sexuality issues	Financial	Parenting	Infidelity
Religious	Cultural Differences	Roles	Mental Illness
Pregnancy	Disability	In-laws	Deployment
Separation	Infertitility	Miscarriages	Health

Other: ____

Total # of Children: ____ # from current partner: _____ # from previous partners: ______

(name, age, full/half-/step-)

____

____

____

Total children living in home: _________

Relationship/Parenting issues with children: Y N NA

Details: ____

____

If you are NOT married, do you have a significant other? Y N

First name ___________________ Age _____ Currently lives where? ____________________

How long have you know each other? ____

How serious is this relationship? ____

Are there any children? Y N Pregnant Miscarriage

Additional ____

Are you happy with your current sex life? Why/Why not? ____________________________

____

Have you had any problems with past relationships? Explain. __________________________

____

Do you have at least one significant friendship that is not romantic? Y N
Have you ever had the same friend for more than a year? Y N
Do you spend times with your friends away from your significant other? Y N
Who do you consider to be your strongest family or social supports? None or List:
____

How would you describe yourself?
____
____

How would OTHERS describe you?

Friendly	Loner	Shy	Outgoing	Laid Back
Generous	Selfish	Haughty	Ugly	Happy
Type “A”	Fun	Humble	Attractive	Complainer
Picky	Mean	Argumentative		Intimidating

Other: ____

Legal History

Current or Pending legal issues: Y N Adult Juvenile
Details: ____
Prior legal issues: ____
Have you ever been incarcerated, if so, when, where and why? Y N
____

Substance Abuse/Use History

***Alcohol/Drug Use: Y N Current Past**

Under the influence now	Been hospitalized	Arrests
Job Loss	DT’s	Family Problems
Blackouts	IV Drug Use	Family Hx

If someone else, who? ________________________

Drug/s of Choice:

None	Alcohol	Marijuana	Tranquilizers
Opiates	Heroin	Barbiturates	Amphetamines
PCP	Cocaine	Crack	Hallucinogen
Inhalants	Prescription Drugs	Cigarettes	Caffeine

Other: ____

Consequences of Substance Abuse:

Hangovers Withdrawal Symptoms Sleep Disturbance Binges Seizures
Medical Conditions Assaults Job Loss Blackouts Tolerance Changes
Suicidal Impulse Arrests Overdose Loss of Control Relationship Conflicts
Other: ____

In Remission: __________________________ Last Use: _______________
Source: Street Family Friends Other: ______________________________

At what age did you start? : ______ How many total years? __________________

Substance, Route, Age of 1st use, Routine Amount, Frequency
Route: *oral, inhale, smoking, inject, other*
Frequency: *None, remission, none in past month, 1-3x mth, 1-2x wk, 3-7x wk, daily*

1.____
2.____
3.____

Withdrawal Symptoms: Y N NA
If yes, details:
____
____
Have you ever been told you have a problem? Y N
Do YOU think you have a problem? Y N
Do you think you NEED treatment? Y N
Are you receptive to treatment? Y N: Inpatient Outpatient
Have you ever been in Rehab? Y N
If yes, when, where and how long?
____
Does anyone in your family have a problem with substance abuse? Y N
Details: ____
____
Additional: ____

Medical History
How do you rate your current physical health? Good Fair Poor
Do you have a PCP that you see regularly? Y N
Who/where are you seen? ____
When was your last doctor's visit? ____________________
Have you had any major illness, hospitalizations or surgeries? If yes, when and where?
____
____
Please circle any of the following major illnesses that run in your family:

Tuberculosis	Heart disease	Birth Defects	High Blood Pressure
Emotional Problems	Behavior Problems	Alcoholism	Drug Abuse
Thyroid Problems	Diabetes	Cancer	Alzheimer's Disease
Dementia	Mental Retardation	Stroke	Other: ______________________

Are you affected by a terminal illness? Y N _________________________________
Are you currently pregnant? Y N
# of pregnancies: ______ # of live births: ___________
Do you suffer from any of the following Medical conditions? Y N
Cancer Hypertension Heart Problems Stroke HIV

Arthritis STD Frequent UTI Diabetes Disability
Other: ____

Current Medications: (med, route, dosage, frequency, for what) NONE or list below or attach list

1. ____
2. ____
3. ____
4. ____
5. ____

How do your meds make you feel? _______________________________________
Drug Allergies: NKA Type: ________________________________

<u>Mental Health History</u>

Have you ever been treated for any mental health/ psychiatric problem/diagnosis? Y N
Have you ever been hospitalized for psychiatric reasons? Y N
If so, when and what for? ____
Previous Counseling/Therapy? Y N
Details: _____________________ ____
____
Family history of mental illness: Y N
Explain: ____
____

Current Psychotropic Medications: (med, route, dosage, frequency, purpose, duration)
1.____
2.____
3. ____
4. ____
How do your meds make you feel? ____
Who prescribes them? ____
Last appointment: _________________**Next appointment:** _____________________

If none: will you consider taking psychotropic meds if indicated by doctor? Y N

Please rate how strongly you are/have experienced the following symptoms (0 – Not applicable to 10 – I am feeling or have felt this <u>very</u> strongly!) and if your rating is for currently (C) or for the past (P).
Example: "Depression: 0P 9C" would mean you have felt no depression in your past but a great deal of depression currently.

Experienced Recent Loss? Y N __________________________________
Depression: ____________________ Appetite: _______________________
Weight changes: _________________ Sleep Problems: ___________________
Poor Concentration: _______________ Isolation/Withdrawal: ________________
Hopelessness: ___________________ Emotionality: _____________________
Grief: ________________________ Poor Grooming: ____________________
Anorexia: ______________________ Laxative/Diuretic use: ________________
Dissociative states: _______________ Somatic Complaints: _________________

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Conduct Problems: ________________ Oppositional Behavior: _________________
Irritability: ______________________ Fatigue: ____________________________
Crying: _________________________ Worthlessness: _______________________
Guilt: ___________________________ Loss of Interest: _____________________
Delusions: ______________________ Hallucinations: _______________________
Paranoia: _______________________ Mood Swings: ___ ____________________
Anxiety: _______________________ Grandiosity: _________________________
Impulsiveness: __________________ Hyper/hyposexuality: __________________
Hyper/Hypoactivity: ______________ Talkative: ___________________________
Compulsive beh: _________________ Obsessive Thoughts: __________________
Panic Attacks: ___________________ Excessive Worry: _____________________
Fears/Phobias: ___________________ Avoidance: ___________________________
Flashbacks: ______________________ Nightmares: __________________________
Dissociative Episodes: ____________ Perfectionism: ________________________
Domestic Violence: _______________ Impaired Memory: ____________________
Frequent Lying: ___________________ Stealing: ____________________________
Bingeing: _________________________ Purging: _____________________________
Sexual Issues: _____________________ Substance Use/Abuse: _________________
Fighting: ________________________ Promiscuity: _________________________
Fire Setting: ______________________ Running Away/desertion: _____________
Property Destruction: _____________ Euphoria: ____________________________
Overspending: ___________________ Self-mutilation: _______________________
Anger Issues: ____________________ Repetitive Behaviors: _________________
Fidgeting: _______________________
Other: ____

HX of Trauma: Y N

Rape Victim	Witness to traumatic event	
Robbery victim	Physical Abuse	Verbal Abuse
Sexual Abuse	Victim of DV	Assault Victim
TBI	PTSD	Shooting Victim
Natural Disaster	Death of Immediate Family Member	

Other: ____

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FOR COUNSELOR INTERVIEW ONLY

Mental Status: **Competent: Y N**

***Orientation/ Sensorium**

Person Place Time Situation

***Brief Physical Description/Appearance:**

General	Height	Posture	Weight	Age
Appropriate	Average	Relaxed	Average	Normal
Well groomed	Short	Stiff	Underweight	Older
Poor Hygiene	Tall	Slouched	Overweight	Younger

Other: ____

***Attitude**

Appropriate	Passive	Passive/Aggressive	Reserved
Cooperative	Resistant	Belligerent	Guarded
Negative	Hostile	Sarcastic	Resentful
Suspicious	Manipulative	Tense	Arrogant
Immature	Other: ______________		

***Motor Activity**

Unremarkable	Restless	Pacing	Tremulous
Hyperactive	Motionless	Tic	Fidgety

Other: ______________________________________

***Affect**

Appropriate	Happy	Bland	Labile
Restricted	Agitated	Subdued	Flat

Other: ______________________________________

***Mood**

Appears Stable	Confused	Apathetic	Fearful
Anxious	Euphoric	Depressed	Angry
Tearful	Other: ______________		

***Thought/Speech**

Normal	Repetitive	Rambling	Slurred
Flight of Ideas	Tangential	Disorganized	Mumbled
Paranoid	Psychotic		

Other: ______________________________________

***Cognitive**

Normal	Overly Concrete	Failed to grasp nature of questions
Easily Distracted	Poor Abstract Thinking	Indecisive
Impressionable	Other: ______________	

Long Term Memory: Intact Difficulties: Mild Moderate Extreme

***Recall: BALL ORANGE CAR**
Short Term Memory: Intact Difficulties: Mild Moderate Extreme

***Insight**
Good Average Poor

HAVE YOU HAD PAST OR CURRENT THOUGHTS OF HARMING YOURSELF OR ANOTHER? Y N ______________________________

***Danger to self or others**

None	Family HX of suicide	Suicidal/Homicidal ideations
Accident Prone	S/H Plans	Probable High Risk
Supervision available	Has Crisis plan	Needs Crisis/Safety Plan

Plans of suicide/homicide: ______________________
Recent suicidal attempts: ______________________
Past suicidal attempts: ______________________
Hx of assault/homicide: ______________________
Hx of self injury: ______________________
Hx of hurting an animal: ______________________

<u>Additional Information:</u>
DO you currently practice religion/spirituality? Y N Details: ______________________
Strengths:
____
____

Deficits/Problems/Needs/Areas of Impairment to address through counseling or via referral:

Coping skills	Anger management	MH symptoms	Community resources
Living Skills	Communication	Social Skills	Transportation
Medications	SA Treatment	Couples Counseling	Parenting
Self Esteem	Grief	Resilience	Recovery

Other: ____
Other Professional Supports Currently in Place:
____
____

Areas of impairment: (GAF): ____ Date: ______________

Marital/Intimacy/Family	Academic	Health	Housing
Spiritual	Vocational	Social	Leisure
Financial	Safety	Legal	Occupational
Support System			

Outstanding issues needing addressed

____

____

____

Ethnic/ Cultural/Individual Considerations:

____

____

____

MH Service/Referral Recommendations: Counseling Referral Medication, etc.

Details:

____

____

This assessment is based on information collected from the following sources:

____

My interview with the following:

____ Patient

____ Family Members: ____

____ Friends: ____

____ Others: ____

____ Review of records (Specify): ____

____ Other sources: ____

Individual Risk Reduction Factors and Individual Risk Factors: *For hospitalized patients, this should include an assessment of the risk of elopement.*

Clinician's Formulation of Risk: *using the risk factors and risk reduction factors identified above, describe your estimation of the consumer's imminent and long term risk for suicide as well as necessary interventions to assure consumer's safety and facilitate stabilization. Describe your clinical reasoning in details.*

Interventions: *Document interventions which directly address mitigating those risk factors which are identified and can be addressed either clinically or with the help of natural supports. For consumers where a formal crisis plan is developed, that may serve to complete this section by attaching a copy of that plan.*

Any Other Special Needs of Client: *Is there anything to take into consideration when developing a treatment plan for the Client?*

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Treatment Planning

In order of significance, what issues do you WANT to focus on in therapy?

____

____

What are your expectations for therapy? When will you know that you made progress or are ready to terminate?

____

____

____

What information/referrals or other assistance would you like us to provide you with, if possible?

____

____

What or who is your best source of support/comfort?

____

Other information not addressed above:

____

____

Releases Needed:

____

____

Tx Goals Identified by Therapist:

____

____

____

END INTERVIEW HERE

If this format will be used/filed as a completed comprehensive psychological evaluation, do not write in margins. Place misc information and notes on the back.