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Adult Biopsychosocial Assessment

General Information

Date: _____ DOB: _____ Age: _____

Full Name: _____

Name you prefer to be called: _____

Address: _____

Mailing address if different from above:

Race: White _____ Black _____ American Indian/Alaskan Native _____ Asian _____
Native Hawaiian/Pacific Islander _____ Multi Racial _____

Ethnicity: Puerto Rican _____ Mexican _____ Cuban _____ Hispanic _____ Haitian _____
Other _____

Marital Status: Never Married _____ Married _____ Widowed _____ Divorced _____
Separated _____

Emergency Contact:

Name: _____ Relationship: _____

Home Number: _____ Work Number: _____

Cell Number: _____

Party responsible for paying the bill:

Client _____ Other: _____ (If other complete below)

Name: _____ Relationship: _____

Home Number: _____ Work Number: _____

Cell Number: _____ SS# _____

Address: _____

I am seeking help for:

- | | |
|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Drug problem |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Alcohol problem |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Homelessness | <input type="checkbox"/> Gambling problem |
| <input type="checkbox"/> Domestic violence/abuse | <input type="checkbox"/> Job problems |
| <input type="checkbox"/> Not sure | <input type="checkbox"/> School problems |

Other: _____

History of Presenting Problem:

I was referred here by:

- | | |
|--|---|
| <input type="checkbox"/> Physician or psychiatrist | <input type="checkbox"/> DCF (Dept. of Children and Families) |
| <input type="checkbox"/> Friend or relative | <input type="checkbox"/> Judge/Court/Legal |
| <input type="checkbox"/> Clergy | <input type="checkbox"/> Probation/Parole Officer |
| <input type="checkbox"/> No one | <input type="checkbox"/> Other: _____ |

In the past year my income has:

- Not changed
 Increased
 Decreased

During the last month, how many days of work or school have you missed?

- | | | |
|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> 0 days | <input type="checkbox"/> 4-6 days | <input type="checkbox"/> 10 or more days |
| <input type="checkbox"/> 1-3 days | <input type="checkbox"/> 7-9 days | <input type="checkbox"/> Not working or in school |

Your goals for therapy:

Relationships and Family

Who lives or stays with you?

Name	Relationship	Part-time	Full-Time

I am currently married or in a significant relationship:

Yes No

If yes, this relationship is:

Good Fair Poor

My current relationship with my friends is:

Good Fair Poor

I receive some emotional support from my family and/or friends:

Yes No

If yes, is it enough?

Yes No

Other source of emotional support:

Overall my childhood was:

Good Fair Poor

As a child, my relationship with my mother was:

Good Fair Poor

As a child, my relationship with my father was:

Good Fair Poor

As a child, my relationships with my friends were:

Good Fair Poor

As a child, my relationships with other family members were:

Good Fair Poor

A significant friend or relative of mine has died in the last year:

Yes No

If yes, who? _____ Cause of death: _____

Please give the name, age, and sex of each of your children:

For each child:	Name	Name	Name	Name	Name
Age					
Sex					

My status as a parent is: (Please check the appropriate box)

Biological parent					
Step parent					
Foster parent					
Adoptive parent					
Other					

Religion and Culture

What are the religious, spiritual, cultural, or ethnic considerations that I should be aware of as I meet with you?

Education

Are you currently enrolled in school/college/training? ___ Yes ___ No

If yes, ___ Full-time ___ Part-time

The highest grade you completed in school was: _____

Was your school experience: ___ Good ___ Fair ___ Poor

Do you want to go back to school or training? ___ Yes ___ No

List degrees, licenses, special training, etc.

Employment

Current Employment:

- Full-time
- Part-time
- Unemployed
- Volunteer work

Name of Employer _____

Describe the work you do:

Length of Service: _____

Relationship with co-workers:
 Good Fair Poor

Relationship with Supervisor:
 Good Fair Poor

Military

Have you served in the military? Yes No

What branch of service? _____

Were you in combat? Yes No

If applicable, please describe your combat service:

Legal

Have you ever been arrested? Yes No

If yes, how many times? _____

If yes, please give details:

Are you currently on probation? ___ Yes ___ No
Are you currently on parole? ___ Yes ___ No
Are you currently in drug court? ___ Yes ___ No
Are you currently in domestic violence court? ___ Yes ___ No

Alcohol and Other Drugs

Do members of your family currently use alcohol or other drugs? ___ Yes ___ No
If yes, who? _____

Do members of your family have a history of using alcohol or drugs?
___ Yes ___ No
If yes, who? _____

At any time in the last 30 days, have you felt that you should reduce or stop:

Smoking cigarettes ___ Yes ___ No ___ Do not use
Smoking marijuana ___ Yes ___ No ___ Do not use
Using alcohol ___ Yes ___ No ___ Do not use
Using drugs ___ Yes ___ No ___ Do not use

Has drinking or taking drugs caused you any problems with school, work, friends,
spouse, police, or your health:

Currently ___ Yes ___ No
Within the last year ___ Yes ___ No

Please explain:

Did alcohol or drugs cause problems for you at one point in your life, but are not a
problem now?

___ Yes ___ No ___ Never used/drank

Has anyone else expressed concern about your drinking or drug use?

___ Yes ___ No ___ Never used/drank

If yes, who? _____

Does your personality change under the influence of alcohol or drugs?

___ Yes ___ No ___ Never used/drank

Have you ever blacked out when drinking?

___ Yes ___ No ___ Never used/drank

Have you ever attended AA? ___ Yes ___ No How long? _____

Have you ever attended NA? ___ Yes ___ No How long? _____

What is the longest time your were clean and sober? _____

Please check the appropriate boxes and fill in the appropriate blanks.

Type of Drug	Never	Last 6 months	Last 48 hours	Age first used	Most used in one day over last 6 months
Alcohol					
Amphetamines: <ul style="list-style-type: none"> • Speed • Uppers • Crystal • Meth • Crank Pills _____ Smoke _____					
Cannabis <ul style="list-style-type: none"> • Marijuana • Pot • Hashish 					
Cocaine/Crack <ul style="list-style-type: none"> • Blow • Rock • Coke • Freebase Powdered _____ Freebase _____					
Hallucinogens <ul style="list-style-type: none"> • LSD • Ecstasy • MDA • DMT • Mescaline • Mushrooms 					
Inhalants <ul style="list-style-type: none"> • Glue • Gasoline • Paint thinner • Spray can propellant 					

Type of Drug	Never	Last 6 months	Last 48 hours	Age First used	Most used in one day over last 6 months
Opioids <ul style="list-style-type: none"> • Heroin • Demerol • Codeine • Morphine • Fentanyl • China white • Methadone Phencyclidine & Similar <ul style="list-style-type: none"> • PCP • Ketamine • “K” 					
Sedatives, Hypnotics & Anxiolytics <ul style="list-style-type: none"> • Barbituates • “Downers” • Benzodiazepines • Xanax • Valium • “Roofies” 					
Other <ul style="list-style-type: none"> • Darvocet • Steroids • GHB • Amyl nitrite • “Poppers” • “Rush” • Painkillers 					
Nicotine <ul style="list-style-type: none"> • Cigarettes • Cigars • Chewing tobacco • Dip 					

Medications

Current Medication

Medication Name	Date Prescribed	Dosage & Frequency	Doctor	Side Effects	Taken as Prescribed?
					<u> </u> Yes <u> </u> No
					<u> </u> Yes <u> </u> No
					<u> </u> Yes <u> </u> No
					<u> </u> Yes <u> </u> No
					<u> </u> Yes <u> </u> No

Previous Medications (last 2 years)

Medication Name	Date Prescribed	Dosage & Frequency	Doctor	Side Effects	Taken as Prescribed?
					<u> </u> Yes <u> </u> No
					<u> </u> Yes <u> </u> No
					<u> </u> Yes <u> </u> No
					<u> </u> Yes <u> </u> No
					<u> </u> Yes <u> </u> No

Medical

Please describe any significant diseases, surgeries, or injuries from your past or present:

Do you have any known allergies, including medication allergies?

 Yes No

If yes, please describe:

Primary Doctor and Phone Number:

Psychiatrist and Phone Number:

Mental Health

Have any members of your family had: (Check all that apply)

- Depression
- Anxiety
- Mental illness If so, what mental illness? _____
- Job problems
- School problems
- Drug/alcoholism problems
- Legal problems
- Gambling problems
- Other _____

Have you previously been to a counselor or psychiatrist?

- Yes No

During the last 6 months, have you thought of seriously hurting yourself or other people?

- Yes No

Have you ever attempted suicide?

- Yes No If so, how many times? _____

Do you currently have plans to harm yourself?

- Yes No If yes, how would you plan to do it? _____

During the last month, how often have you been getting out of the house to do what you usually do during the day?

- Never Seldom Often Very frequently

During the last month, how often have you been getting out of the house to do thing you enjoy?

- Never Seldom Often Very frequently

Are you concerned about sexual issues, past or present?

- Yes No If yes, please explain:

Have there been times in the past when your appetite changed significantly?

- Yes No

Your weight the last 6 months:

- Maintained the same weight
- Gained _____ pounds
- Lost _____ pounds

Appetite during the last month:

Normal Eating more than normal Poor

Have you had sleep problems in the past?

Yes No

Have there been times when you didn't need much sleep?

Yes No

Your usual sleep pattern is: (Check all that apply)

- Normal sleep
- Problem falling asleep
- Problems staying asleep
- Nightmares
- Irregular sleep
- Sleep too much

Violence and Trauma

Were you ever a victim of a violent crime?

Yes No Age _____

Were you ever raped?

Yes No Age _____

When you were a child, were you ever touched or fondled in a sexual way that made you feel uncomfortable, or were you made to touch/fondle someone in a sexual way?

Yes No Age _____

If yes, did this happen more than once?

Yes No

Were you ever forced to have sex by your spouse/significant other?

Yes No

Has anyone stalked you, in other words, followed you or kept track of your activities, causing you to feel intimidated or concerned for your safety?

Yes No

If yes, please describe:

Are you currently afraid of someone harming you in?

Yes No

If yes, please explain:

If you answered yes to any of the above questions about violence and sexual trauma, do you currently experience any of the following?

Flashbacks Yes No

Nightmares Yes No

Insomnia Yes No

Fearfulness Yes No

Numbness Yes No

Other Yes No

If other, please explain:

Strengths & Abilities

What of the following will help you in therapy? (Check all that apply and list others you think will help.)

Support from family (parents, children, others)

Support from spouse or significant other

Support from friends

Connection to self-help group (AA, NA, etc.)

A positive and supportive sponsor

Connection to a church group or minister

Counselor or case manager

Psychiatrist

Judge or probation officer

Employer

Financial security, assistance or benefits

Permanent residence

I am very motivated about treatment.

I am able to make an appropriate transition to living in a recovering community.

I have good interpersonal skills.

I have good emotion-management skills.

I have good reasoning and analytical skills.

I have am able to recognize my problems.

I have good self-esteem.

- I have some positive plans and goals for my future.
 - I am willing to do whatever it takes to be more functional and peaceful.
 - I have a good relationship with a Higher Power.
 - I have areas of my life in which I take pleasure.
 - I have good work skills and work experience.
 - I have an education.
 - Other:
-
-
-
-

Needs

What do you want to derive from therapy? (Check all that apply and list others you think of that are not shown.)

- More thorough understanding of my problems
 - Improvement in my interpersonal skills/relationships
 - Improvement in my communication skills
 - Contact with supportive people
 - Emotion management skills
 - Anger management skills
 - Personal safety plan
 - Parenting skills
 - Obtaining and keeping a job
 - Education regarding my health
 - Relapse prevention
 - Coping skills
 - Referral to a mental health facility
 - Referral to a psychiatrist
 - Other:
-
-
-
-