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:** ▢ BIO H0031 HN ▢ GT ▢ IDA ▢ H0031 ▢ HC ▢ GT

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Behavior & Attitude	▢ Cooperative ▢ Withdrawn ▢ Agitated	▢ Guarded ▢ Hostile ▢ Disruptive	▢ Belligerent ▢ Combative ▢ Oppositional		▢ Dramatic ▢ Manipulative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

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

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Depressed Symptoms - Cause	▢ Sadness ▢ Withdrawn ▢ Mania	▢ Helplessness ▢ Anhedonia ▢ Mood Swing	▢ Hopelessness ▢ Low Self-esteem ▢ Low self-worth	▢ Depressed mood ▢ Anger/Aggression ▢ Low motivation	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

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

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

4. BEHAVIORAL HEALTH ASSESSMENT

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

▢ Place	▢ Delusion (specify)	▢ Recent appetite changes
▢ Person	▢ Inattention/Easily Distracted	▢ Sleep Disturbance (explain)
▢ Time	▢ Hyperactivity	▢ Recent change in Weight
▢ Irritability	▢ Experienced traumatic event	▢ Nightmares
▢ Aggressive/Angry Behavior	▢ Panic attack	▢ Drinking Alcohol
▢ Impulsive/Risky Behavior	▢ Paranoia	▢ Taking drugs
▢ Non-Compliant	▢ Depressed Mood	▢ Fear/Phobias
▢ Auditory/Visual Hallucinations	▢ Suicidal Thinking	▢ Anxiety
▢ Social Problems	▢ 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:	▢
Do you own a weapon? If yes, explain:	▢
Does client have a plan or access to plan or individual?	▢
Have you ever been hospitalized for depressive symptoms? If yes, detail:	▢
Have the client received another behavioral health service in the last 2 years? If yes, specify:	▢

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, or financial exploitation)

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 two 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.

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?	▢Yes ▢No
Eats fewer than 2 meals per day?	▢Yes ▢No
Eats few fruits, vegetables, or milk products.	▢Yes ▢No
Have 3 or more drinks of beer, liquor, or wine almost every day.	▢Yes ▢No
Have tooth or mouth problems that make it hard to eat.	▢Yes ▢No
Does not always have enough money to buy the food needed.	▢Yes ▢No
Eats alone most of the time.	▢Yes ▢No
Takes 3 or more different prescribed or over-the-counter drugs a day.	▢Yes ▢No
Without wanting to, has lost or gained 10 pounds in the last 6 months.	▢Yes ▢No
Not always physically able to shop, cook, and/or feed self.	▢Yes ▢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**
▢ Diminished ▢ Increased ▢ WNL ▢ Anorexia	▢ Diminished ▢ Increased fluid ▢ Restricted Fluids ▢ WNL ▢ Inadequate	▢ Intended ▢ Unintended ▢ Gain ▢ 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 ▢Cohabitating

- If married or cohabitating, 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