Family Service Society, Inc.
Biopsychosocial Worksheet

Client Name: _____ **Sex:** M or F **Date of Birth:** __/__/____ **Age**:_____ **Language:** _____

Address:_____ **City:**_____ **Phone:** (____)____-_____ **Marital Status**:_____

Religion:_____ **Race**:_____**Ethnicity**: Hispanic Non-Hispanic SS#_____

Presenting Problem (include duration, if applicable):_____

_____

Current Symptoms (Check if they apply and rate intensity on a scale of 1-10, 1 being minor and 10 most severe):

__depressed mood: _____
__fatigue/low energy: _____
__mood swings: _____
__irritability: _____
__phobias: _____
__laxative/ diuretic abuse: _____
__delusions: _____
__conduct problems: _____
__grief: _____
__worthlessness: _____
__hyperactivity: _____
__self-harm: _____
__physical trauma victim: _____
__substance abuse: _____
__appetite disturbance: _____
__poor concentration: _____
__agitation: _____
__generalized anxiety: _____
__obsessions/compulsions: _____
__anorexia: _____
__hallucinations: _____
__oppositional behavior: _____
__hopelessness: _____
__guilt: _____
__dissociative states: _____
__significant weight gain/loss: _____
__sexual trauma victim: _____
__other: _____: _____
__sleep disturbance: _____
__poor grooming: _____
__emotionality: _____
__panic attacks: _____
__binging/purging: _____
__paranoid ideation: _____
__aggressive behaviors: _____
__sexual dysfunction: _____
__social isolation: _____
__elevated mood: _____
__somatic complaints: _____
__emotional trauma victim: _____
__perpetrator of trauma: _____

Personal Status

Sexual Orientation: Heterosexual Homosexual Bisexual Transgender Other:_____

Relationship Status: never married married ___times divorced___ times widowed separated partner

Satisfied with current relationship: Yes No N/A **Why Not:**_____

Current Living Situation: _____**Is it adequate, why**:_____

Education: _____

Employment/ Income: _____

Military Service: Yes No **Branch:**_____ **Year Discharged:**_____ **Honorable:** Yes No

Spiritual Beliefs:_____

Supports: Other Significant Family/Friends/Organizations_____

_____

Current Community Resources Obtained:_____

Mental Health History:

Current/ Last Seen Psychiatrist:_____ **Date of Last Appointment**:_____

Mental Illness Diagnosis:_____

Psychotropic medications usage/diagnosis:_____

_____

Inpatient: Yes No **Details** (Date, Reason, Duration, Location)_____

_____

Outpatient: Yes No **Details** (Date, Reason, Duration, Location)_____

_____

Family Psychiatric History:_____

_____

Family Use of Psychotropic Medications:_____

Childhood/Family History:

Where were you born:_____**Bio Mother Name**:_____ **Bio Father Name**:_____

Did your parent's divorce/separate? If so, what was your age? _____ **Did they remarry?** _____

Family Issues (circle those that apply):

domestic violence poverty sexual promiscuity criminal behavior mental illness neglect of children frequent unemployment excessive gambling alcohol/drug abuse sex abuse physical abuse emotional abuse

Repercussion of issues circled above: _____

Living situation when you grew up:_____

Childhood Family Experience: __Outstanding __Normal __Chaotic __Witness Abuse __Experienced Abuse

Academic Issues in School: _____

Siblings:

Name	Current Age	Other Parent, if Different	Status of Relationship

Marriages: Yes No **If yes, spouses names**_____

Children:

Child's Name	Other Parent's Name	Sex	Current Age	Live with you?	Current Relationship Status Close/ Distant

Early Childhood Experiences:

Most Positive Events/ Age	Most Negative Events/ Age

Medical History and Current Status:

Primary Care Physician:_____ **City:**_____**Phone#:**_____

Current Physical Health: Good Fair Poor **Last Physical or Dr Appointment:**_____

Medical Conditions/ Allergies:_____

Family History of Medical Conditions:_____

Serious Childhood Illnesses/ age:_____

Any Serious Illnesses/ Hospitalizations/ Accidents/Surgeries:_____

Any Abnormal Lab Test Results:_____

Childhood Developmental/Emotional/Behavior/Social/Intellectual Problems: _____

_____

_____