Bio-Psycho-Social History

Personal History

Client Name:_____ Date:_____ DOB:_____

Age:_____ Gender:_____ Birthplace:_____

Ethnic Background: _____ Language Spoken in Home:_____

How many times in the past year have you changed residence? _____ Past 2 years _____ Past 3 years _____

Past 5 years _____ Past 10 years _____ Past 20 years _____

Mother's Name:_____ Aprox. Age:_____ Occupation:_____

Father's Name:_____ Aprox. Age:_____ Occupation: _____

Married Years:_____ Divorced Years _____ Their Relationship: Fair Strained Strong

Describe your relationship with your parents:_____

_____

If divorced, did your parents remarry? Mother Father Describe your relationship with your step-parent(s):

_____

Custody Schedule:_____

Client Relationship Status: Married Single In long-term relationship Length of Time:_____

Your Children: Girls/Ages _____ Boys/Ages_____

Describe your relationship with your children:_____

_____

Health History

Height:_____ Weight:_____ Physical Condition: Excellent Good Fair Poor

Describe your physical fitness routine:_____

Describe any physical or mental health limitations or problems you have had and are currently experiencing:_____

_____

_____

Surgeries & Dates:_____

Are you under care of a PCP: Yes No When was your last exam:_____ Reason:_____

List any current prescribed medications, for what condition, and prescribing physician name:_____

_____

Have you ever been diagnosed for chemical abuse? Yes No Dates:_____ Outcome:_____

Treatment:_____

List dates, treating provider, & outcomes of any past psychological or psychiatric services:_____

_____

Any Illnesses/Complications during pregnancy:_____

After Delivery/Length of stay: _____

Any medication, alcohol, tobacco or other substances used during pregnancy: _____

_____

Developmental Milestones (in months): Sat up_____ Walked_____ Talked in Sentences_____ Weaned___

____ Fed Oneself_____ Tied Own Shoes_____ Toilet Trained (any issues):_____

Please describe any Traumatic experiences (car accidents, abuse, domestic violence, robbery, war, etc...) include dates, any treatment received & outcomes_____

_____

Any notable problems with the following: Depression_____ Anger_____

Anxiety_____ Grief_____ Behaviors_____

Social Skills_____ Attachment _____ Attention _____

Hyperactivity_____ Low Energy_____ Sleep _____

Family Medical & Psychiatric History- Please indicate whom in space provided

Maternal Paternal

Client Name:_____

Alcoholism _____ _____
Drug Abuse_____ _____
Mental Illness_____ _____
Psychiatric Hospitalization_____ _____
Developmental Delay_____ _____
Learning Disability_____ _____
Suicide/Attempts_____ _____
Medical Illness_____ _____

Education

What is the highest grade of school completed:_____ Name of Current School:_____
Circle degrees earned: GED High School Diploma B.A. /B.S. M.A. /M. S. Ph.D.
Additional Professional Degrees or Certificates:_____
Are you interested in furthering your education? Yes No In what/where?_____
Are you/were you ever enrolled in any special education courses? Yes No Describe:_____
_____
Describe any learning or behavioral challenges experienced/ currently experiencing in school:_____
_____
Ever repeated a grade, please describe which & why:_____
Describe Interactions with teachers:_____
Please rate how well you are/did perform in the following subject areas:

	Failure	Below Avg	Average	Above Avg
Reading, English, Language Arts	☐	☐	☐	☐
Mathematics	☐	☐	☐	☐
History, Social Studies	☐	☐	☐	☐
Science	☐	☐	☐	☐
_____	☐	☐	☐	☐

Occupation/Finances

Where do your currently work?_____ How long?_____
Rate your level of satisfaction with your work: Love it Like it It's okay Dislike it Can't stand it
Please describe:_____
Any challenges maintaining employment? _____

If unemployed, describe why and duration:_____
_____
If unemployed, describe current source of income:_____
Please describe any financial difficulties you may be experiencing:_____

Spirituality

Please describe your current spiritual beliefs, affiliations, and practices:_____
_____
Have you ever held different beliefs? Please describe what they were and any significant reason for this change:_____
_____

Leisure/Recreation

Client Name:_____

Please list any extracurricular groups/activities you are involved in and for how long:_____

_____

Describe your hobbies:_____

Describe activities do you engage to relax:_____

Is your social activity with peers of your own age? _____ Older? _____ Younger? _____

How do you spend time with your friends? _____

Do you have any close friends? _____ How many?_____ Acquaintances?_____ How many?_____

Significant relationships with family:_____

Favorite TV Programs/computer activities:_____

Describe Daily Routine (wake, eating, tv, socializing, sleep, etc...)

:_____

_____

Discipline

Please describe including frequency and reason for type of discipline you received or are receiving:

Time Out & Duration_____

Removing Privledges_____

Lecture_____

Shout, yell, scream_____

Threaten to discipline but not follow through_____

Spank on bottom with bare hand_____

Hit with object(s)_____

Slap on hand, arm, leg _____

Slap on face, head, ear_____

Self Report Rational for Treatment

Please describe your present concerns about yourself or your child and what you believe is contributing to the issue.

_____

_____

_____

Please describe when symptoms appeared. Note any other significant occurrences that may relate to onset.

_____

_____

_____

Please describe who (school, court, etc...) referred you and how you have attempted to address the problem already.

_____

_____

_____

Please include any other information you believe is relevant but not answered earlier:_____

_____

_____

Client Signature_____ Date_____

Parent Signature (if applicable)_____ Date_____

Reina Lombardi, ATR-BC, LMHC_____ Date_____

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