Biopsychosocial Assessment

Complete at intake. The three domains feed the clinical summary; the summary feeds the treatment plan. The client sets the pace on trauma content.

Client name: _____ Pronouns: _____ Date of birth: _____

Date of assessment: _____ Clinician / credential: _____ Referral source: _____

1 Identifying information

Age, relationship status, household, occupation or school, and anything the client wants known about identity (culture, language, faith, orientation).

2 Presenting problem

In the client's own words: what brings them in, when it started, what makes it better or worse, and why now.

3 Biological

Current medical conditions:

Current medications (name / dose / prescriber):

Allergies:

Sleep (hours, quality, changes):

Appetite and nutrition:

Substance use (alcohol, cannabis, nicotine, caffeine, prescription misuse, other; amount and frequency):

Family medical history:

Developmental history (if relevant):

4 Psychological

Mental health history (prior therapy, diagnoses, hospitalizations, what helped):

Current symptoms (onset, duration, severity):

Mental status observations:

Coping strategies and strengths:

Cognition (concentration, memory, insight, judgment):

Trauma history (brief; the client sets the pace):

Risk assessment (SI/HI, plan, intent, means, history of attempts or self-harm, protective factors):

5 Social

Family and household composition:

Relationships and supports:

Housing (status, stability):

Work or school:

Financial stressors:

Legal involvement:

Culture, religion, spirituality:

Community and leisure:

6 Clinical summary and formulation

Two or three paragraphs: what is happening, which biological, psychological, and social factors contribute, and what maintains the problem.

7 Diagnostic impressions (provisional)

Within your scope; note the basis for each impression.

8 Recommendations and initial treatment plan

Frequency and modality, referrals and coordination of care, client goals, review date.

Clinician signature

Date