LifeMark

Biopsychosocial Assessment

1. Presenting Problem

Why are you seeking counseling?

2. Identification

Name:	Gender:	Date:
Preferred Name:	Date of Birth:	Age:
Address:		
Home Phone:	Cell:	
Ok to leave messages? ☐ Yes ☐ No	Ok to send mail to address? ☐ Yes ☐ No	
Ethnicity:	Religious Orientation:	
Email:	Marital Status:	
Emergency Contact: Relationship to Client:	Emergency Contact's Phone:	
How did you hear about LifeMark?	Referred to LifeMark by:	

If Minor:

Parent/Guardian (Mother):	Phone:
Parent/Guardian (Father):	Phone:
If joint custody is held, does the other parent authorize treatment for child? ☐ Yes ☐ No ☐ N/A	

3. History of Presenting Problem (Check all symptoms that apply.)

- ☐ Sad Moods
- ☐ Crying Frequently
- ☐ Mood Swings
- ☐ Hostile/Angry moods
- ☐ Lack of Motivation
- ☐ Violent Temper
- ☐ Disobedient
- ☐ Extreme Worry
- ☐ Indecisive
- ☐ Seeing Things Others Don't
- ☐ Self-Injuries
- ☐ Threats/Acts
- ☐ Hyperactive
- ☐ Poor Concentration
- ☐ Impulsive
- ☐ Daydreaming
- ☐ Suicidal Ideation
- ☐ Drug/Alcohol Use
- ☐ Chronic Lying
- ☐ Hearing Things Others Don't
- ☐ Stealing
- ☐ Fire-Setting
- ☐ Assaulting Others
- ☐ Bizarre Behavior
- ☐ Distrustful
- ☐ Not Trustworthy
- ☐ Homicidal Ideation
- ☐ Changes in Sleep
- ☐ Changes in Eating
- ☐ Other: _____

Start of Symptoms:	Duration of Symptoms:	Frequency of Symptoms:

4. Past Psychiatric/Counseling History

Prior Treatment: Date:	Symptoms/Diagnosis: Provider:	Hospitalizations (Inpatient): ☐ Yes ☐ No Date(s): _____ Suicide Attempts: ☐ Yes ☐ No Date(s): _____

5. Trauma History

Trauma Experienced: ☐ Physical ☐ Verbal ☐ Emotional ☐ Sexual	Trauma Witnessed: ☐ Physical ☐ Verbal ☐ Emotional ☐ Sexual	Major Stress-Inducing or Life-Threatening Events: ☐ Divorce ☐ Work-Related ☐ Military-Related ☐ Family/Care-Giving ☐ Other:

6. Family Psychiatric/Mental Health History

Has any family member struggled with mental illness or substance use? ☐ Yes ☐ No
If yes, please list:

Name	Relation	When	Diagnosis/Symptoms

7. Medical Conditions & History

Current Medical Conditions:_____

Past Medical Conditions:_____

Allergies:_____

Current Medications

Medication	Dosage	Purpose	Prescribing Physician

8. Addiction History

- ☐ Alcohol
- ☐ Pornography
- ☐ Gambling
- ☐ Other: _____
- ☐ Drugs
- ☐ Sex
- ☐ Social Media
- ☐ Cigarettes
- ☐ Food
- ☐ Gaming

Start Date:	Frequency:	Last Use:

9. Family History

Childhood Experience: ☐ Outstanding Home Environment ☐ Normal Home Environment ☐ Chaotic Home Environment	Special Circumstances in Childhood:

Mother: ☐ Present Entire Childhood ☐ Present Part of Childhood ☐ Not Present	Father: ☐ Present Entire Childhood ☐ Present Part of Childhood ☐ Not Present	Step-Mother: ☐ Present Entire Childhood ☐ Present Part of Childhood ☐ Not Present
Step-Father: ☐ Present Entire Childhood ☐ Present Part of Childhood ☐ Not Present	Brother(s): # _____ ☐ Present Entire Childhood ☐ Present Part of Childhood ☐ Not Present	Sister(s): #_____ ☐ Present Entire Childhood ☐ Present Part of Childhood ☐ Not Present
Half/Step Sibling(s): # ____ ☐ Present Entire Childhood ☐ Present Part of Childhood ☐ Not present	Adopted: ☐ Foster Care Who has guardianship if in foster care? _____	Other: ☐ Present Entire Childhood ☐ Present Part of Childhood ☐ Not present

Describe Parents

Mother's Name:	Father's Name:
Education:	Education:
Occupation:	Occupation:
Parent's Current Marital Status:	☐ Married ☐ Widowed ☐ Separated for _____ years ☐ Divorced for _____ years

10. List all persons currently living in your household.

Name	Age	Sex	Relationship

List all biological/adopted children NOT living in the household.

Name	Age	Sex	Relationship

11. Social History (Check all that apply.)

Social Support System
- ☐ Supportive Network
- ☐ Few Friends
- ☐ Substance-Use-Based on Friends
- ☐ No Friends
- ☐ Distant from Family Origin

Social Interaction
- ☐ Normal
- ☐ Authority Conflicts
- ☐ Intellectual Disability
- ☐ Distrustful
- ☐ Social Anxiety

Romantic Relationship Status
- ☐ Never Been in a Serious Relationship
- ☐ Single
- ☐ Dating
- ☐ In a Relationship

Sexual History

Sexual Orientation: _____

Age of 1st Sexual Experience: _____

History of Promiscuity Age _____ to _____

History of Unsafe Sex Age _____ to _____

☐ Engaged
☐ Cohabitating
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Age of 1st Pregnancy/Fatherhood: _____
Number of Pregnancies: _____
Number of Miscarriages/Abortions: _____

Romantic Relationship Satisfaction
☐ Very Satisfied
☐ Satisfied
☐ Dissatisfied
☐ Very Dissatisfied
☐ N/A

Sexual Satisfaction
☐ Very Satisfied
☐ Satisfied
☐ Dissatisfied
☐ Very Dissatisfied
☐ N/A

12. Developmental History (Please indicate any delayed developmental milestones.)

☐ Sitting
☐ Controlling Bladder
☐ Controlling Bowels
☐ Playing
☐ Rolling Over
☐ Standing
☐ Riding Tricycle
☐ Sleeping Alone
☐ Dressing Self
☐ Feeding Self
☐ Speaking Words
☐ Walking
☐ Engaging Peers
☐ Toleration of Separation
☐ Other: _____

13. Educational/Occupational History

Current Employer:	Occupation:
School Attending:	Highest Level of Education:
Concentration:	IEP or 504 Plan? ☐ Yes ☐ No ☐ N/A
Military Service/Veteran? ☐ Yes ☐ No	Family Member Military Service/Veteran? ☐ Yes ☐ No

Current Employment/Schooling Satisfaction
☐ Very Satisfied
☐ Satisfied
☐ Dissatisfied
☐ Very Dissatisfied
☐ N/A

Financial Satisfaction
☐ Very Satisfied
☐ Satisfied
☐ Dissatisfied
☐ Very Dissatisfied
☐ N/A

14. Legal History

Parole/Probation:	Court-ordered Counseling:
Arrests:	Jail/Prison:

15. Strengths/Limitations

Please describe strengths you may bring to treatment:	Please describe possible limitations you may bring to treatment:

16. Therapy Goals

17. Anything else you would like your therapist to know?

Signature: _____ **Date:** _____