Biopsychosocial History – 90791/H0031-HO

Date of intake: XX/XX/XXXX
Client Name: XXXXX XXXXXX
Address: XXX XXX Avenue
Member's Age: DOB XX/XX/XXXXX
Sex:
(intake document for all items below)
Ethnicity:
Marital Status: Single
Emergency Contact: Mother: XXX XXX XXXXX
Guardian:
Psychiatric Advanced Directives: offered to client and parent/see documentation

Chief Complaint/Presenting Problem ("why now" for referral to outpatient therapy):
"Why Now" – What event increased symptoms and functional impairments?
What is the history of the symptoms/impairments?
What environments are the impairments demonstrated/experienced?
What does the client /family want therapy to help change?

Family Dynamics
What is the current living situation?
Who does the client live with?
How does the client describe the support/relationships?
Are there other supports?
Other Social History Information**:** Divorces, separations, moves, job loss, traumatic experiences, legal, victimization

Mental Health History (gather on intake documents and confirm during interview – summarize in final document)
Previous providers
Previous diagnoses
Previous medications
Outcomes of past treatments

Medical History (gather on intake documents and confirm during interview – summarize in final document)
Suggest medical history document at intake
Summarize developmental issues, chronic medical conditions,
Medications
Allergies/adverse reactions

Substance Abuse History (gather on intake document and confirmed during interview- summarize in final document)

Substance	Amount	Frequency	Duration	First Use	Last Use
Tobacco					
Alcohol					
Marijuana					
Opioids/ Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					
Caffeine					

Academic (children/adolescents) Work/Occupation (adolescent/adults)
Grade level
Performance/grades:
Learning/behavioral issues
Suspensions/excessive absences
Peer relationships
Occupation:
Work history:

Personal Assets and Liabilities
List client use of coping skills
Hobbies/interests/achievements
Liabilities/barriers to meeting goals of therapy

Mental Status

Appearance: Note a person's dress, cleanliness, habits, posture, appropriateness for age, ability to form and maintain eye contact
Behavior: Describe any mannerisms (peculiar and characteristic goal directed behaviors, stereotypies (repetitive and abnormal non-goal-directed behavior), posturing (striking a pose and maintaining it), presence of waxy flexibility (resistance of limbs to passive motion) catalepsy (maintaining of any position), tremor, agitation, psychomotor retardation, or signs of extra pyramidal symptoms of tardive dyskinesia.
Speech: Describe the rate, tone, rhythm volume, general quality and presence of any latency (a pause or several seconds before responding to a question).
Emotion: Describe the quality, type, stability, range, intensity and appropriateness of a person's emotional state Describe the person's mood, sustained emotional state, and affect (i.e., the observable behaviors that are expression of emotion.

Thought Process: Describe how a person thinks, and note any evidence of loosening of associations. Ranging from:
Intact
Circumstantial (providing unnecessary details but eventually answering a question)
Tangential (only touching upon the question at hand)
Loose (providing responses unrelated to a question)
Flight of ideas (nearly continuous flow of speech based on an understandable but distracting group of associations)
Word salad (random use of words)
Distractibility (being easily diverted by extraneous stimuli)
Derailment (running ideas into each other)
Perseveration/verbigeration (prolonged repetition of isolated words)
Echolalia (repetition of words or statements of others)
Neologisms (creation of words)
Clang association (choosing words purely for sound)
Alliteration
Push of speech (increased, rapid speech that is often loud and difficult to interrupt)
Decreased latency of response (answering questions before you can finishing asking them)
Increased latency of response
Poverty of speech
Blocking (sudden stops in the middle of a thought sequence)
Mutism (absence of speech)
Aphonia (ability to only whisper or croak)
Thought Content: Comment on what the person discusses, including the presence of ideation, intent, or plan to harm self or others
Phobias (intense, unreasonable fears of a specific object, activity or situation
Obsession (recurrent, persistent idea, image or desire that dominates thought)
Compulsion (irresistible impulse to perform an action)
Hallucination (the perception of an absent stimulus)
Illusion (misperception of an actual stimulus)
Delusions (fixed, firm, false beliefs that are not part of a person's culture or religion)
Persecution
Paranoia
Grandiosity
Thought Insertion
Thought withdrawal
Guilt
Passivity
Ideas of reference (perceptions that unrelated stimuli have a particular and unusual meaning specific to the person)

Cognition and Intellectual Resources
Observe a person's orientation, recent and remote memory, ability to calculate and ability to abstract to interpret proverbs. Comment on the person's insight and judgment, especially as they relate to the presenting condition**.**
(Adapted from APA Pocket Guide to the DSM-5 Diagnostic Exam, 2013)

Risk Assessment

	None Noted	Thoughts Only	Plan (describe)	Intent (describe)	Means (describe)	Attempt (describe)	Able to Contract for Safety
Suicidal Ideation							
Homicidal Ideation							

Risk Factors:
Non-compliance with treatment
Domestic Violence
AMA/elopement potential
Child Abuse
Prior behavioral health inpatient admissions
Sexual Abuse
History of multiple behavioral diagnoses
Eating Disorder
Suicidal/homicidal ideation
Other (describe)

For Symptoms/impairments supporting current diagnosis see DSM 5 or:
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level2
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Disorder
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Disability
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Personality
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Early
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Cultural

Outcomes 360
http://www.magellanofnebraska.com/for-providers-ne/outcomes.aspx
Consumer Health Inventory (CHI)
Consumer Health Inventory – child version (CHI-C)
CANS – Child Adolescent Needs and Strengths Assessment

Functional Impairments:
What is the intensity of the symptoms?
What is the duration of the sysmptoms?
What is the severity of the symptoms?
In what environments does the client experience the symptoms?

DSM 5 Diagnosis: (example only)
309.81-Post-Traumatic Stress Disorder;
296.22 Major Depression, moderate, single episode;
G43 Migraine headaches with aura
995.54 Child Physical Abuse, confirmed,
Initial 995.53 Child Sexual Abuse, confirmed, initial

2. Treatment Recommendations:

- ✓ Treatment needs and recommended interventions for client and family
- ✓ Identification of who needs to be involved in the client's treatment
- ✓ Overall plan to meet the treatment needs of the client including transitioning to lower levels of care and discharge planning
- ✓ A means to evaluate the client's progress throughout their treatment and outcome measures at discharge- baseline of physical health and emotional health using the Consumer Health Inventory (CHI or CHI-C) and readminister after 2-3 months of treatment or Child Adolescent Needs and Strengths assessment
- ✓ Recommended linkages with other community resources
- ✓ Other areas that may need further evaluation
- ✓ The family will go the emergency room or call 911 in the event of an emergency.

Supervisor/Diagnostician/Clinician

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Signature/Date/License