

# Wyndhurst Counseling Center

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## INTAKE / BIOPSYCHOSOCIAL HISTORY FORM

(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### CLIENT INFORMATION

Client's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)		Birth Date / /	Age
Mailing Address		City	State	ZIP Code	Social Security	Home Phone No. (    )
E-mail Address					Cell Phone No. (    )	
School	Grade	Employer (if applicable)			Employer Phone No. (    )	
Referred by (Please check one box)				<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other _____		

### PRESENTING PROBLEMS

Presenting problems	Duration (months)	Additional information:
_____	_____	_____
_____	_____	_____
_____	_____	_____

### CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

**None** = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

**Moderate** = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	headaches	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]	physical complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	cannot make decisions	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) _____	[ ]	[ ]	[ ]	[ ]

**EMOTIONAL/PSYCHIATRIC HISTORY**

**[ ] [ ] Prior outpatient psychotherapy?**

No Yes If yes, on \_\_\_\_\_ occasions. Longest treatment by \_\_\_\_\_ for \_\_\_\_\_ sessions from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Provider Name Month/Year Month/Year

Prior provider name City State Phone Diagnosis Intervention/Modality Beneficial?  
\_\_\_\_\_  
\_\_\_\_\_

**[ ] [ ] Has any family member had outpatient psychotherapy? If yes, who/why (list all):** \_\_\_\_\_  
No Yes

**[ ] [ ] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**

No Yes If yes, on \_\_\_\_\_ occasions. Longest treatment at \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of facility Month/Year Month/Year

Inpatient facility name City State Phone Diagnosis Intervention/Modality Beneficial?  
\_\_\_\_\_  
\_\_\_\_\_

**[ ] [ ] Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes,**  
No Yes who/why (list all): \_\_\_\_\_

**[ ] [ ] Prior or current psychotropic medication usage? If yes:**

No Yes Medication Dosage Frequency Start date End date Physician Side effects Beneficial?  
\_\_\_\_\_  
\_\_\_\_\_

**[ ] [ ] Has any family member used psychotropic medications? If yes, who/what/why (list all):** \_\_\_\_\_  
No Yes

**FAMILY HISTORY**

**FAMILY OF ORIGIN**

**Present during childhood:**

Present Present Not  
entire part of present  
childhood childhood at all  
mother [ ] [ ] [ ]  
father [ ] [ ] [ ]  
stepmother [ ] [ ] [ ]  
stepfather [ ] [ ] [ ]  
brother(s) [ ] [ ] [ ]  
sister(s) [ ] [ ] [ ]  
other (specify) [ ] [ ] [ ]

**Parents' current marital status:**

[ ] married to each other  
[ ] separated for \_\_\_\_ years  
[ ] divorced for \_\_\_\_ years  
[ ] mother remarried \_\_\_\_ times  
[ ] father remarried \_\_\_\_ times  
[ ] mother involved with someone  
[ ] father involved with someone  
[ ] mother deceased for \_\_\_\_ years  
age of patient at mother's death \_\_\_\_  
[ ] father deceased for \_\_\_\_ years  
age of patient at father's death \_\_\_\_

**Describe parents:**

**Father** **Mother**  
full name \_\_\_\_\_  
occupation \_\_\_\_\_  
education \_\_\_\_\_  
general health \_\_\_\_\_

**Describe childhood family experience:**

[ ] outstanding home environment  
[ ] normal home environment  
[ ] chaotic home environment  
[ ] witnessed physical/verbal/sexual abuse toward others  
[ ] experienced physical/verbal/sexual abuse from others

**Age of emancipation from home:** \_\_\_\_\_ **Circumstances:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Special circumstances in childhood:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMEDIATE FAMILY**

**Marital status:**

- single, never married
- engaged \_\_\_ months
- married for \_\_\_ years
- divorced for \_\_\_ years
- separated for \_\_\_ years
- divorce in process \_\_\_ months
- live-in for \_\_\_ years
- \_\_\_ prior marriages (self)
- \_\_\_ prior marriages (partner)

**Intimate relationship:**

- never been in a serious relationship
- not currently in relationship
- currently in a serious relationship

**Relationship satisfaction:**

- very satisfied with relationship
- satisfied with relationship
- somewhat satisfied with relationship
- dissatisfied with relationship
- very dissatisfied with relationship

**List all persons currently living in patient's household:**

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**List children not living in same household as patient:**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Frequency of visitation of above: \_\_\_\_\_

**Describe any past or current significant issues in intimate relationships:** \_\_\_\_\_

**Describe any past or current significant issues in other immediate family relationships:** \_\_\_\_\_

**MEDICAL HISTORY** (check all that apply for patient)

**Describe current physical health:**  Good  Fair  Poor

**List name of primary care physician:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

**List name of psychiatrist: (if any):**

Name \_\_\_\_\_ Phone \_\_\_\_\_

**List any medications currently being taken** (give dosage & reason):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List any known allergies:** \_\_\_\_\_

**List any abnormal lab test results:**

Date \_\_\_\_\_ Result \_\_\_\_\_  
Date \_\_\_\_\_ Result \_\_\_\_\_

**Is there a history of any of the following in the family:**

- tuberculosis  heart disease
- birth defects  high blood pressure
- emotional problems  alcoholism
- behavior problems  drug abuse
- thyroid problems  diabetes
- cancer  Alzheimer's disease/dementia
- mental retardation  stroke
- other chronic or serious health problems \_\_\_\_\_

**Describe any serious hospitalization or accidents:**

Date \_\_\_\_\_ Age \_\_\_\_\_ Reason \_\_\_\_\_  
Date \_\_\_\_\_ Age \_\_\_\_\_ Reason \_\_\_\_\_  
Date: \_\_\_\_\_ Age \_\_\_\_\_ Reason \_\_\_\_\_

**SUBSTANCE USE HISTORY** (check all that apply for patient)

**Family alcohol/drug abuse history:**

- father  stepparent/live-in
- mother  uncle(s)/aunt(s)
- grandparent(s)  spouse/significant other
- sibling(s)  children
- other \_\_\_\_\_

**Substances used:**

(complete all that apply)

- alcohol
- amphetamines/speed
- barbiturates/owners
- caffeine
- cocaine
- crack cocaine
- hallucinogens (e.g., LSD)
- inhalants (e.g., glue, gas)
- marijuana or hashish
- nicotine/cigarettes
- PCP
- prescription \_\_\_\_\_
- other \_\_\_\_\_

**Current Use**

First use age	Last use age	(Yes/No)	Frequency	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Substance use status:**

- no history of abuse
- active abuse
- early full remission
- early partial remission
- sustained full remission
- sustained partial remission

**Treatment history:**

outpatient (age[s] \_\_\_\_\_)

**Consequences of substance abuse** (check all that apply):

hangovers  withdrawal symptoms  sleep disturbance  binges

- |  |                                      |  |   |                                   |
|--|--------------------------------------|--|---|-----------------------------------|
| <input type="checkbox"/> inpatient (age[s]_____)       | <input type="checkbox"/> seizures    | <input type="checkbox"/> medical conditions          | <input type="checkbox"/> assaults               | <input type="checkbox"/> job loss |
| <input type="checkbox"/> 12-step program (age[s]_____) | <input type="checkbox"/> blackouts   | <input type="checkbox"/> tolerance changes           | <input type="checkbox"/> suicidal impulse       | <input type="checkbox"/> arrests  |
| <input type="checkbox"/> stopped on own (age[s]_____)  | <input type="checkbox"/> overdose    | <input type="checkbox"/> loss of control amount used | <input type="checkbox"/> relationship conflicts |                                   |
| <input type="checkbox"/> other (age[s]_____)           | <input type="checkbox"/> other _____ |  |   |                                   |
| describe:_____   |                                      |  |   |                                   |

**DEVELOPMENTAL HISTORY** (check all that apply for a child/adolescent patient)

- |  |   |   |
|--|---|---|
| <b>Problems during mother's pregnancy:</b>   | <b>Birth:</b>                                     | <b>Childhood health:</b>  |
| <input type="checkbox"/> none                | <input type="checkbox"/> normal delivery          | <input type="checkbox"/> chickenpox (age _____)                 |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> difficult delivery       | <input type="checkbox"/> German measles (age _____)             |
| <input type="checkbox"/> kidney infection    | <input type="checkbox"/> cesarean delivery        | <input type="checkbox"/> red measles (age _____)                |
| <input type="checkbox"/> German measles      | <input type="checkbox"/> complications _____      | <input type="checkbox"/> rheumatic fever (age _____)            |
| <input type="checkbox"/> emotional stress    | birth weight ___lbs ___oz.                        | <input type="checkbox"/> whooping cough (age _____)             |
| <input type="checkbox"/> bleeding            | <b>Infancy:</b>                                   | <input type="checkbox"/> scarlet fever (age _____)              |
| <input type="checkbox"/> alcohol use         | <input type="checkbox"/> feeding problems         | <input type="checkbox"/> autism                                 |
| <input type="checkbox"/> drug use            | <input type="checkbox"/> sleep problems           | <input type="checkbox"/> ear infections                         |
| <input type="checkbox"/> cigarette use       | <input type="checkbox"/> toilet training problems | <input type="checkbox"/> allergies to _____                     |
| <input type="checkbox"/> other _____         |   | <input type="checkbox"/> significant injuries _____             |
|  |   | <input type="checkbox"/> chronic, serious health problems _____ |
|  |   | <input type="checkbox"/> lead poisoning (age _____)             |
|  |   | <input type="checkbox"/> mumps (age _____)                      |
|  |   | <input type="checkbox"/> diphtheria (age _____)                 |
|  |   | <input type="checkbox"/> poliomyelitis (age _____)              |
|  |   | <input type="checkbox"/> pneumonia (age _____)                  |
|  |   | <input type="checkbox"/> tuberculosis (age _____)               |
|  |   | <input type="checkbox"/> mental retardation                     |
|  |   | <input type="checkbox"/> asthma                                 |

**Delayed developmental milestones** (check only those milestones that **did not** occur at expected age):

- |  |  |
|--|--|
| <input type="checkbox"/> sitting             | <input type="checkbox"/> controlling bowels    |
| <input type="checkbox"/> rolling over        | <input type="checkbox"/> sleeping alone        |
| <input type="checkbox"/> standing            | <input type="checkbox"/> dressing self         |
| <input type="checkbox"/> walking             | <input type="checkbox"/> engaging peers        |
| <input type="checkbox"/> feeding self        | <input type="checkbox"/> tolerating separation |
| <input type="checkbox"/> speaking words      | <input type="checkbox"/> playing cooperatively |
| <input type="checkbox"/> speaking sentences  | <input type="checkbox"/> riding tricycle       |
| <input type="checkbox"/> controlling bladder | <input type="checkbox"/> riding bicycle        |
| <input type="checkbox"/> other _____         |  |

**Emotional / behavior problems** (check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> drug use        | <input type="checkbox"/> repeats words of others | <input type="checkbox"/> distrustful         |
| <input type="checkbox"/> alcohol abuse   | <input type="checkbox"/> not trustworthy         | <input type="checkbox"/> extreme worrier     |
| <input type="checkbox"/> chronic lying   | <input type="checkbox"/> hostile/angry mood      | <input type="checkbox"/> self-injurious acts |
| <input type="checkbox"/> stealing        | <input type="checkbox"/> indecisive              | <input type="checkbox"/> impulsive           |
| <input type="checkbox"/> violent temper  | <input type="checkbox"/> immature                | <input type="checkbox"/> easily distracted   |
| <input type="checkbox"/> fire-setting    | <input type="checkbox"/> bizarre behavior        | <input type="checkbox"/> poor concentration  |
| <input type="checkbox"/> hyperactive     | <input type="checkbox"/> self-injurious threats  | <input type="checkbox"/> often sad           |
| <input type="checkbox"/> animal cruelty  | <input type="checkbox"/> frequently tearful      | <input type="checkbox"/> breaks things       |
| <input type="checkbox"/> assaults others | <input type="checkbox"/> frequently daydreams    | <input type="checkbox"/> other _____         |
| <input type="checkbox"/> disobedient     | <input type="checkbox"/> lack of attachment      |  |

**Social interaction** (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> normal social interaction | <input type="checkbox"/> inappropriate sex play           |
| <input type="checkbox"/> isolates self             | <input type="checkbox"/> dominates others                 |
| <input type="checkbox"/> very shy                  | <input type="checkbox"/> associates with acting-out peers |
| <input type="checkbox"/> alienates self            | <input type="checkbox"/> other _____                      |

**Intellectual / academic functioning** (check all that apply):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> normal intelligence | <input type="checkbox"/> authority conflicts | <input type="checkbox"/> mild retardation     |
| <input type="checkbox"/> high intelligence   | <input type="checkbox"/> attention problems  | <input type="checkbox"/> moderate retardation |
| <input type="checkbox"/> learning problems   | <input type="checkbox"/> underachieving      | <input type="checkbox"/> severe retardation   |
| Current or highest education level _____     |  |   |

Describe any other developmental problems or issues: \_\_\_\_\_

**SOCIO-ECONOMIC HISTORY** (check all that apply for patient)

- |  |  |   |
|--|--|---|
| <b>Living situation:</b>                                 | <b>Social support system:</b>                                      | <b>Sexual history:</b>  |
| <input type="checkbox"/> housing adequate                | <input type="checkbox"/> supportive network                        | <input type="checkbox"/> heterosexual orientation   |
| <input type="checkbox"/> homeless                        | <input type="checkbox"/> few friends                               | <input type="checkbox"/> currently sexually dissatisfied  |
| <input type="checkbox"/> housing overcrowded             | <input type="checkbox"/> substance-use-based friends               | <input type="checkbox"/> homosexual orientation   |
| <input type="checkbox"/> dependent on others for housing | <input type="checkbox"/> no friends                                | <input type="checkbox"/> age first sex experience _____   |
| <input type="checkbox"/> housing dangerous/deteriorating | <input type="checkbox"/> distant from family of origin             | <input type="checkbox"/> bisexual orientation   |
| <input type="checkbox"/> living companions dysfunctional |  | <input type="checkbox"/> age first pregnancy/fatherhood _____   |
|  |  | <input type="checkbox"/> currently sexually active  |
|  |  | <input type="checkbox"/> history of promiscuity age ___ to ___  |
|  |  | <input type="checkbox"/> currently sexually satisfied   |
|  |  | <input type="checkbox"/> history of unsafe sex age __ to ___  |
|  |  | Additional information: _____   |
| <b>Employment:</b>                                       | <b>Military history:</b>   | <b>Cultural/spiritual/recreational history:</b>   |
| <input type="checkbox"/> employed and satisfied          | <input type="checkbox"/> never in military                         | cultural identity (e.g., ethnicity, religion): _____  |
| <input type="checkbox"/> employed but dissatisfied       | <input type="checkbox"/> served in military - no incident          | _____   |
| <input type="checkbox"/> unemployed                      | <input type="checkbox"/> served in military - <b>with</b> incident | describe any cultural issues that contribute to current problem: _____  |
| <input type="checkbox"/> coworker conflicts              |  | _____   |
| <input type="checkbox"/> supervisor conflicts            | <b>Legal history:</b>  | currently active in community/recreational activities? Yes <input type="checkbox"/> No <input type="checkbox"/> |

<input type="checkbox"/> unstable work history	<input type="checkbox"/> no legal problems	formerly active in community/recreational activities? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> disabled: _____	<input type="checkbox"/> now on parole/probation	currently engage in hobbies? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Financial situation:</b>	<input type="checkbox"/> arrest(s) not substance-related	currently participate in spiritual activities? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> no current financial problems	<input type="checkbox"/> arrest(s) substance-related	if answered "yes" to any of above, describe: _____
<input type="checkbox"/> large indebtedness	<input type="checkbox"/> court ordered this treatment	_____
<input type="checkbox"/> poverty or below-poverty income	<input type="checkbox"/> jail/prison _____ time(s)	_____
<input type="checkbox"/> impulsive spending	total time served: _____	
<input type="checkbox"/> relationship conflicts over finances	describe last legal difficulty: _____	
	_____	

**SOURCES OF DATA PROVIDED ABOVE:**  Patient self-report for all  A variety of sources (if so, check appropriate sources below):

**Presenting Problems/Symptoms**

patient self-report  
 patient's parent/guardian  
 other (specify) \_\_\_\_\_

**Family History**

patient self-report  
 patient's parent/guardian  
 other (specify) \_\_\_\_\_

**Developmental History**

patient self-report  
 patient's parent/guardian  
 other (specify) \_\_\_\_\_

**Emotional/Psychiatric History**

patient self-report  
 patient's parent/guardian  
 other (specify) \_\_\_\_\_

**Medical/Substance Use History**

patient self-report  
 patient's parent/guardian  
 other (specify) \_\_\_\_\_

**Socioeconomic History**

patient self-report  
 patient's parent/guardian  
 other (specify) \_\_\_\_\_

1. Do you have a family history of mental illness or substance abuse? If so, please explain.

\_\_\_\_\_  
 \_\_\_\_\_

2. Have you ever been treated for substance abuse? If so, when, where, and for what substances?

\_\_\_\_\_  
 \_\_\_\_\_

3. Have you ever attempted suicide or had a plan to harm yourself? When?

\_\_\_\_\_  
 \_\_\_\_\_

4. Do you currently have any thoughts or feelings of wanting to physically harm yourself? If so, please describe your plan.

\_\_\_\_\_  
 \_\_\_\_\_

5. Have you ever been diagnosed with an eating disorder? If so, please describe.

\_\_\_\_\_  
 \_\_\_\_\_

6. Have you been sexually abused or do you worry that you might have been? \_\_\_\_\_

7. Briefly describe any medical history you feel is affecting your well being?

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8. Has your eating and/or sleeping habits changed in the last 3 months? Please describe.

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9. Please describe your current academic functioning.

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10. Please describe your social functioning.

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11. What are your goals for counseling?

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