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BioPsychosocial Assessment

Demographic Information

Name (Last, First, and Middle) _____ Date: _____

Date of Birth (MM/DD/YYYY) _____ Age: _____

Gender assigned at birth: Male Female Other: _____

Current Gender Expression: Male Female Other: _____

Address: _____

Phone Number: _____ Okay to Leave a Message? Yes No

Race/Ethnicity: _____ Preferred Language: _____ Culture: _____

Sexual Orientation: _____ Preferred Choice of Sexual Partners: Male Female Both

Living Arrangement: Homeless Independent living Other (specify): _____

Have you been in a controlled environment in the past 30 days (e.g. Jail, Hospital, Treatment) Yes

No (specify)

Explanation of why patient is currently seeking treatment: Current symptoms, functional impairment, severity, duration of symptoms (e.g., unable to work/school/relationship/housing problems):

What does the patient hope to get from treatment? (in patients own words):

Personal/Social History

Religion/Spirituality/Faith Background Yes No (specify)

Currently Practice? Active None

Highest Grade Completed in school: _____ GED Yes No N/A

If you did not graduate explain why: _____

Do you currently have any or ever had any behavioral, learning disabilities, or traumatic experiences that are significant to educational history? Yes No (explain)

Do you need assistance with Reading/Writing Yes No (specify) _____

Will this have an adverse affect on your ability to receive counseling? Yes No (explain)

Do you use any assistive devices (e.g. Wheelchair, walking devices, hearing aids, etc) Yes No

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(specify) _____

Military Service Yes No (specify which branch, length of service and discharge type):

Do you have an Advance Directive Yes No

Family History

Member	Name	Age/ deceased?	History of alcohol or drug issues or mental illness?(specify)	Quality of relationship
Father				
Mother				
Sibling				

Who were you raised by? Parents One Parent Relatives Foster Adoptive

Describe your childhood (e.g. home atmosphere, moved a lot)? _____

Type of residence you grew up in _____ Economic Status _____

Any developmental issues while growing up (e.g. developmental milestones such as crawl/walk/talk on time) Yes No Unsure (specify)

Are you aware of any pregnancy or delivery issues Yes No Unsure (specify)

What types of things do you like to do for fun? _____

Do you have any children (list names and ages) Yes No

What are your:

Strengths _____

Needs _____

Abilities _____

Preferences _____

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Dimension 1: Substance Use, Acute Withdrawal and/or Withdrawal Potential

1. Substance use history:

Alcohol or Drug Type	Recently Used? (past 6 months)	Prior Use (Lifetime)	Route (inject, smoke, snort)	Amount used	Age at first use?	Current Frequency (daily, weekly, monthly)	Duration (length of use)	Date of last use
Amphetamines (meth, ice, crank)	<input type="radio"/>	<input type="radio"/>						
Alcohol	<input type="radio"/>	<input type="radio"/>						
Cocaine/Crack	<input type="radio"/>	<input type="radio"/>						
Heroin	<input type="radio"/>	<input type="radio"/>						
Marijuana	<input type="radio"/>	<input type="radio"/>						
Opioid Pain Medications <i>misuse or without a prescription</i>	<input type="radio"/>	<input type="radio"/>						
Sedative (Benzos, sleeping pills) <i>misuse or without a prescription</i>	<input type="radio"/>	<input type="radio"/>						
Hallucinogens	<input type="radio"/>	<input type="radio"/>						
Inhalants	<input type="radio"/>	<input type="radio"/>						
Over the counter medication (cough syrup, diet aids)	<input type="radio"/>	<input type="radio"/>						
Nicotine	<input type="radio"/>	<input type="radio"/>						
Other:	<input type="radio"/>	<input type="radio"/>						

Additional Information: _____

2. Do you find yourself using more alcohol and/or drugs than you intend to? Yes No

Please describe: _____

3. Do you get physically ill when you stop using alcohol and/or drugs? Yes No

Please describe: _____

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4. Are you currently experiencing withdrawal symptoms, such as tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting, etc.? Yes No

Please describe specific symptoms: _____

5. Do you have a history of serious withdrawal, seizures, or life-threatening symptoms during withdrawal? Yes No

Please describe and specify withdrawal substance(s): _____

6. Do you find yourself using more alcohol and/or drugs in order to get the same high? Yes No

Please describe: _____

7. Has your alcohol and/or drug use changed recently (increase/decrease, changed route of use)?

Yes No

Please describe: _____

9. Have any of your family members been to treatment for alcohol and/or drug use (specify who and when): _____

Please circle one of the following levels of severity

Severity Rating- Dimension 1 (Substance Use, Acute Withdrawal and/or Withdrawal Potential)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
No signs of withdrawal/intoxication present	Mild/moderate intoxication, interferes with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and Symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

Additional Comments: _____

Dimension 2: Biomedical Conditions and Complications

10. Please list Medical Provider(s):

Physician Name	Specialty	Contact Information

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Please circle one of the following levels of severity

Severity Rating- Dimension 2 (Biomedical Conditions and Complications)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
Fully functional/ able to cope with discomfort or pain.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, nonlife-threatening problems present, or serious biomedical problems are neglected.	Serious medical problems neglected during outpatient or intensive outpatient treatment. Severe medical problems are present but stable. Poor ability to cope with physical problems.	incapacitated with severe medical problems

Additional Comments: _____

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

15. Do you consider any of the following behaviors or symptoms to be problematic?

Mood

- Depression/sadness
 Loss of Pleasure/Interest
 Hopelessness
 Irritability/Anger
 Impulsivity
 Pressured Speech
 Grandiosity
 Racing Thoughts

Anxiety

- Anxiety/Excessive Worry
 Obsessive Thoughts
 Compulsive Behaviors
 Flashbacks

Psychosis

- Paranoia
 Delusions: _____
 Hallucinations: _____

Other

- Sleep Problems
 Memory/Concentration
 Gambling
 Risky Sex Behaviors
 Were the Risky Sexual Behaviors done while under the influence of alcohol and/or drugs: Yes No
 Suicidal Thoughts: please describe _____
 Thoughts of Harming Others: please describe _____
 Experienced Abuse (specify: physical, emotional, sexual, neglect): _____
 Witnessed Abuse (specify: physical, emotional, sexual, neglect) _____
 Traumatic Event(s): _____

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Other: _____

16. Have you ever been diagnosed with a mental illness? Yes No Not Sure

Please describe (e.g. diagnosis, medications?): _____

17. Are you currently or have you previously received treatment for psychiatric or emotional problems?

Yes No Please describe (e.g., treatment setting, hospitalizations, duration of treatment): _____

18. Do you ever see or hear things that other people say they do not see or hear? Yes No

Please describe: _____

19. Question to be answered by interviewer: Based on previous questions, is further assessment of mental health needed? Yes No

Please describe: _____

20. List current medication(s) for psychiatric condition(s):

Medication	Dose/Frequency	Reason	Effectiveness/Side Effects

21. Please list mental health Provider(s):

Physician Name	Contact Information

Please circle one of the following levels of severity

Severity Rating- Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe
Good impulse control and coping skills. No dangerousness, good social functioning and self-care, no interference with recovery.	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting	incapacitated with severe medical problems

Additional Comments: _____

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Dimension 4: Readiness to Change

22. Is your alcohol and/or drug use affecting any of the following?

- Work Mental Health Physical Health Finances
 School Relationships Sexual Activity Legal Matters
 Handling Everyday Tasks Self-esteem Hygiene Recreational Activities

Other: _____

Explain _____

23. Do you continue to use alcohol or drugs despite having it affect the areas listed above? Yes

No

Please describe: _____

24. Have you received help for alcohol and/or drug problems in the past? Yes No

Please list treatment Provider(s):

Facility or Physician Name	Contact Information

25. What would help to support your recovery _____

26. What are potential barriers to your recovery (e.g., financial, transportation, relationships, etc.)? _____

27. How important is it for you to receive treatment for:

Alcohol Problems: Not at all Slightly Moderately Considerably Extremely

Drug Problems: Not at all Slightly Moderately Considerably Extremely

Please describe: _____

28. Internal Motivators _____

29. External Motivators _____

30. Question to be answered by interviewer: Stage of change _____

Please circle one of the following levels of severity

Severity Rating- Dimension 4 (Readiness to Change)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe

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Insight and judgement are intact regarding problem and recovery.	Slight insight into the problem. Ambivalent to the need to change.	Reluctant to change substance use. Passive engagement in treatment. Lacks appropriate insight into the problem.	Unaware of the need to change. Resistant to follow through with recommendations for treatment. Complete lack of insight into problems.	Unwilling/unable to follow through with treatment recommendations.
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Additional Comments: _____

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

31. In the last 30 days, how often have you experienced cravings, withdrawal symptoms, disturbing effects of use?

- Alcohol: None Occasionally Frequently Constantly
 Drug: None Occasionally Frequently Constantly

32. Do you find yourself spending time searching for alcohol and/or drugs, or trying to recover from its effects? Yes No

Please describe: _____

33. Do you feel that you will either relapse or continue to use without treatment or additional support?

- Yes No

Please describe: _____

34. Are you aware of your triggers to use alcohol and/or drugs? Yes No

Please check off any triggers that may apply:

- Strong Cravings Work Pressure Mental Health Relationship Problems
 Financial Stressors Physical Health School Pressure Environment
 Unemployment Chronic Pain Peer Pressure Difficulty Dealing with Feelings
 Other _____

35. What do you do if you are triggered? _____

36. Can you please describe any attempts you have made to either control or cut down on your alcohol and/or drug use? _____

37. What is the longest period of time that you have gone without using alcohol and/or drugs? _____

38. What helped and didn't help? _____

Please circle one of the following levels of severity

Severity Rating- Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe

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Low/no potential for relapse. Good ability to cope.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition of risk for relapse, poor skills to cope with relapse.	No coping skills for relapse/addiction problems. Substance use/behavior, places self/other in imminent danger.
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Additional Comments: _____

Dimension 6: Recovery/Living Environment

39. Do you have any relationships that are supportive of your recovery? (e.g., family, friends) _____

40. What is your current living situation (e.g., homeless, living with family/alone)? _____

41. Do you currently live in an environment where others are using drugs? Yes No
 Please describe: _____

42. Are you currently involved in relationships or situations that pose a threat to your safety? Yes No
 Please describe: _____

43. Are you currently involved in relationships or situations that would negatively impact your recovery?
 Yes No
 Please describe: _____

44. Are you currently employed or enrolled in school? Yes No
 Please describe (e.g., where employed, duration of employment, name and type of school): _____

Past Employment History (where and for how long): _____

45. Are you currently involved with social services or the legal system (e.g., DCFS, court mandated, probation, parole)? Yes No
 Please describe: _____

If on parole or probation:

Name of parole or probation officer	Contact Information

Please circle one of the following levels of severity

Severity Rating- Dimension 6 (Recovery/Living Environment)				
0-None	1- Mild	2-Moderate	3- Severe	4- Very Severe

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Able to cope in environment/ supportive.	Passive/disinterested social support, but still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment, difficulty coping even with clinical structure.	Environment toxic/hostile to recovery. Unable to cope and the environment may pose a threat to safety.
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Additional Comments: _____

Diagnosis: DSM-V Criteria for Substance Use Disorder

	Substance Use Disorder Criteria	#1	#2	#3
1	Substance often taken in larger amounts or over a longer period than was intended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Craving, or a strong desire or urge to use the substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Recurrent substance use in situations in which it is physically hazardous.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Tolerance, as defined by either of the following: - A need for markedly increased amounts of the substance to achieve intoxication or desired effect. - A markedly diminished effect with continued use of the same amount of the substance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Withdrawal, as manifested by either of the following: - The characteristic withdrawal syndrome for the substance. - Substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Total Number of Criteria			
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Please check off any symptoms that have occurred in the past 12 months.

List of Substance Use Disorder(s) that Meet DSM-5 Criteria and Date of DSM-5 Diagnosis (specify severity level):

* The presence of at least 2 of these criteria indicates a substance use disorder.

** The severity of the substance use disorder is defined as:

- Mild: Presence of 2-3 criteria
- Moderate: Presence of 4-5 criteria
- Severe: Presence of 6 or more criteria

Placement Summary

Level of Care: Enter the ASAM Level of Care number that offers the most appropriate treatment setting given the client's current severity and functioning: _____

Level of Care Provided: If the most appropriate Level of Care is not utilized, then enter the next appropriate Level of Care and check off the reason for this discrepancy (below):

Reason for Discrepancy:

- | | | | |
|---|---|---|---|
| <input type="radio"/> Not Applicable | <input type="radio"/> Service Not Available | <input type="radio"/> Provider Judgment | <input type="radio"/> Client Preference |
| <input type="radio"/> Transportation | <input type="radio"/> Accessibility | <input type="radio"/> Financial | <input type="radio"/> Preferred to Wait |
| <input type="radio"/> Language/ Cultural Considerations | <input type="radio"/> Environment | <input type="radio"/> Mental Health | |
| <input type="radio"/> Physical Health | <input type="radio"/> Other: | | |

Briefly Explain Discrepancy: _____

Designated Treatment Location and Provider Name: _____

Interpretative Summary: _____

Therapist Name

Signature

Date