BIOPSYCHOSOCIAL HISTORY

Patient's Information	
Patient's Name:	
Date of Birth (DOB) and Age:	
Date of Service:	
CHIEF COMPLAINT:	
In the PAST TWO WEEKS have you experienced any of the following: Check All That Applies)	
___Anger	___Anxiety
___Change in your appetite	___Easily distracted
___Depression	___Getting into fights
___Fatigue	___Impulsivity
___Forgetfulness	___Increased energy (even when not sleeping
___Hallucinations	___Obsessions (intrusive repetitive thoughts)
___Homicide thoughts	___Other
___Low self esteem	___Panic attacks
___Manic episode	___PhobiasCompulsions (repetitive acts that are unreasonable)
___Mood swings	___Racing thoughts
___Paranoia	___Thoughts of suicide
___Sleep disturbance	Others
___Wishing your were dead	
MEDICAL AND MENTAL HISTORY	***(Answer YER or NO (Explain "yes" answer)***
Patient Psychiatric History:	
Psychiatric history:	
Prior Hospitalizations:	
Prior Suicide Attempts:	
Self Destructive Behavior:	
History of Aggressive Behavior:	
Previous Psychiatric Treatments	***( ) YES ( ) NO (Explain "yes" answer)***
Diagnosis:	
Treatment:	
Allergies:	
Alcohol and Drug history	
Tobacco:	**( ) Yes ( ) NO ( ) Socially**
Alcohol:	**( ) Yes ( ) NO ( ) Socially**
Drugs:	**( ) Yes ( ) NO ( ) Socially**
Past Psychiatric History comment	
Family Psychiatric History:	***( ) No psychiatric history in family***
History of Suicide/Suicide Attempts:	( ) Father ( ) Mother ( ) Siblings (Other)
Other	
Family history comments:	

Patient Medical History	
Surgeries:	
Allergies:	
Medical Conditions:	***( ) Patient denies medical conditions***
( ) Hypertension or cardiac problems	( ) Gastroesophageal complaint
( ) Diabetes	( ) Thyroid problems
( ) Hyperlipidemia	( ) Hepatic condition
Other medical conditions:	
Medication History	***(Current medication taken)***
Psychiatric:	
Medical:	
Social History	
Marital status:	( ) Single ( ) Married ( ) Divorced ( ) Widow
Family Support:	( )Yes ( ) No
Lives alone:	( )Yes ( ) No
Homeless:	( )Yes ( ) No
Employed:	( )Yes ( ) No
Social History comments:	
Trauma History:	
Personal Strengths:	
( ) Motivated toward treatment	( ) Independent living skills
( ) Introvision to their condition/situation	( ) Practice some sport or hobby
( ) Family/friends support	( ) History of treatment compliance
( ) Good physical health	( ) Level of educational attainment______________________
( ) Working or attending school	( ) Other

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Patient signature Date

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Physician signature Date