BIOPSYCHOSOCIAL HISTORY

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
depressed mood	○	○	○	○
appetite disturbance	○	○	○	○
sleep disturbance	○	○	○	○
elimination disturbance	○	○	○	○
fatigue/low energy	○	○	○	○
slow movements	○	○	○	○
poor concentration	○	○	○	○
poor grooming	○	○	○	○
mood swings	○	○	○	○
agitation	○	○	○	○
emotionality	○	○	○	○
irritability	○	○	○	○
generalized anxiety	○	○	○	○
panic attacks	○	○	○	○
phobias	○	○	○	○
obsessions/compulsions	○	○	○	○

	None	Mild	Moderate	Severe
bingeing/purging	○	○	○	○
laxative/diuretic abuse	○	○	○	○
anorexia	○	○	○	○
paranoid ideas	○	○	○	○
overly detailed thoughts	○	○	○	○
jumping from topic to topic	○	○	○	○
delusions	○	○	○	○
hallucinations	○	○	○	○
aggressive behaviors	○	○	○	○
conduct problems	○	○	○	○
oppositional behavior	○	○	○	○
sexual dysfunction	○	○	○	○
grief	○	○	○	○
hopelessness	○	○	○	○
social isolation	○	○	○	○
worthlessness	○	○	○	○

	None	Mild	Moderate	Severe
guilt	○	○	○	○
elevated mood	○	○	○	○
hyperactivity	○	○	○	○
losing track of time or place	○	○	○	○
somatic complaints	○	○	○	○
self-mutilation	○	○	○	○
significant weight gain/loss	○	○	○	○
a medical condition	○	○	○	○
emotional trauma victim	○	○	○	○
physical trauma victim	○	○	○	○
sexual trauma victim	○	○	○	○
emotional trauma perpetrator	○	○	○	○
physical trauma perpetrator	○	○	○	○
sexual trauma perpetrator	○	○	○	○
substance abuse	○	○	○	○
other (specify)	○	○	○	○

EMOTIONAL/PSYCHIATRIC HISTORY

○ No ○ Yes **Prior outpatient psychotherapy?**
If yes, on _____ occasions. Longest treatment by _____ for ___ sessions from ___/_____ to _____/_____

Prior provider name	City	State	Provider Name Phone	Diagnosis	Month/Year Intervention/Modality	Month/Year Beneficial?

○ No ○ Yes **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?**
If yes, on _____ occasions. Longest treatment at _____ from ___/_____ to _____/_____

Inpatient facility name	City	State	Name of facility Phone	Diagnosis	Month/Year Intervention/Modality	Month/Year Beneficial?

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

○ No ○ Yes **Prior or current psychotropic medication usage?** If yes:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

○ No ○ Yes **Has any family member used psychotropic medications?** If yes, who/what/why (list all):
_____

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FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present 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):

_____

_____

_____

_____

Is there a history of any of the following: -for self

○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 _____

_____ _____ _____

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Client Name _____ D.O.B. _____ Client SS# _____ Date _____

List any known allergies: _____ Date_____ Age_____ Reason_____

_____ Date:_____ Age_____ Reason_____

List any abnormal lab test results:

Date _____ Result _____

Date _____ Result _____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

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

Substance use status: -for self

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

Substances used:
(complete all that apply)

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

Treatment history: -for self

- outpatient (age[s]_____)
- inpatient (age[s]_____)
- 12-step program (age[s]_____)
- stopped on own (age[s]_____)
- other (age[s]_____)

describe: _____

Consequences of substance abuse (check all that apply):

- hangovers
- seizures
- blackouts
- overdose
- withdrawal symptoms
- medical conditions
- tolerance changes
- loss of control amount used
- sleep disturbance
- assaults
- suicidal impulse
- relationship conflicts
- binges
- job loss
- arrests
- other _____

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

Problems during mother's pregnancy:

- none
- high blood pressure
- kidney infection
- German measles
- emotional stress
- bleeding
- alcohol use
- drug use
- cigarette use
- other _____

Birth:

- normal delivery
- difficult delivery
- cesarean delivery
- complications

_____

birth weight___lbs___ oz.

Infancy:

- feeding problems
- sleep problems
- toilet training problems

Childhood health:

- chickenpox (age_____)
- German measles (age_____)
- red measles (age_____)
- rheumatic fever (age_____)
- whooping cough (age_____)
- scarlet fever (age_____)
- autism
- ear infections
- allergies to_____
- significant injuries_____
- chronic, serious health problems_____
- lead poising (age_____)
- mumps (age_____)
- diphtheria (age_____)
- poliomyelitis (age_____)
- pneumonia (age_____)
- tuberculosis (age_____)
- mental retardation
- asthma

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

- sitting
- rolling over
- standing
- walking
- feeding self
- speaking words
- speaking sentences
- controlling bladder
- controlling bowels
- sleeping alone
- dressing self
- engaging peers
- tolerating separation
- playing cooperatively
- riding tricycle
- riding bicycle
- other _____

Emotional / behavior problems (check all that apply):

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

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Social interaction (check all that apply):

- ◯ normal social interaction
- ◯ isolates self
- ◯ very shy
- ◯ alienates self
- ◯ inappropriate sex play
- ◯ dominates others
- ◯ associates with acting-out peers
- ◯ other _____

Intellectual / academic functioning (check all that apply):

- ◯ normal intelligence
- ◯ high intelligence
- ◯ learning problems
- ◯ authority conflicts
- ◯ attention problems
- ◯ underachieving
- ◯ mild retardation
- ◯ moderate retardation
- ◯ severe retardation

Current or highest education level _____

Describe any other developmental problems or issues:

_____

_____

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

Living situation:

- ◯ housing adequate
- ◯ homeless
- ◯ housing overcrowded
- ◯ dependent on others for housing
- ◯ housing dangerous/deteriorating
- ◯ living companions dysfunctional

Employment:

- ◯ employed and satisfied
- ◯ employed but dissatisfied
- ◯ unemployed
- ◯ coworker conflicts
- ◯ supervisor conflicts
- ◯ unstable work history
- ◯ disabled:_____

Financial situation:

- ◯ no current financial problems
- ◯ large indebtedness
- ◯ poverty or below-poverty income
- ◯ impulsive spending
- ◯ relationship conflicts over finances

Social support system:

- ◯ supportive network
- ◯ few friends
- ◯ substance-use-based friends
- ◯ no friends
- ◯ distant from family of origin

Military history:

- ◯ never in military
- ◯ served in military - no incident
- ◯ served in military - with incident

_____

_____

Legal history:

- ◯ no legal problems
- ◯ now on parole/probation
- ◯ arrest(s) not substance-related
- ◯ arrest(s) substance-related
- ◯ court ordered this treatment
- ◯ jail/prison_____time(s)
- ◯ total time served:_____
- ◯ describe last legal difficulty:

_____

_____

Sexual history:

- ◯ heterosexual orientation
- ◯ homosexual orientation
- ◯ bisexual orientation
- ◯ currently sexually active
- ◯ currently sexually satisfied
- ◯ currently sexually dissatisfied
- ◯ age first sex experience_____
- ◯ age first pregnancy/fatherhood_____
- ◯ history of promiscuity age____ to_____
- ◯ history of unsafe sex age____ to_____

Additional information: _____

_____

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion):

_____

describe any cultural issues that contribute to current problem:

_____

currently active in community/recreational activities? Yes ◯ No ◯

formerly active in community/recreational activities? Yes ◯ No ◯

currently engage in hobbies? Yes ◯ No ◯

currently participate in spiritual activities? Yes ◯ No ◯

if answered "yes" to any of above, describe:

_____

_____

_____

_____

_____

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)_____

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Lake Howell Health Center
Consent/HIPPA Form

Financial Policy/Authorization to release inform to insurance company
I, Undersigned, certify that I (or my dependent) has insurance coverage as listed above and assign directly to LLHC understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of copayments, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Lake Howell Health Center (LHHC) to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.
Signature X_____Date:_____
Are you the Guarantor? Yes____No____ If not please see the receptionist.

Consent for Treatment & Release information to pharmacy/consulting physician/hospitals
Having voluntarily presented myself (or my dependent) LHHC I acknowledge recognition of the fact that the evaluation and treatment received, I also give LHHC permission to discuss RX history, advised or deemed necessary, to be the judgment of the physician.
Signature X_____Date:_____

Acknowledgement of receipt of privacy notice (HIPPA)
Health Insurance Portability and Accountability Act
By signing this form, you acknowledge that LHHC has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in a various situations. We must attempt to have you sign this form on you first date of service with us after April 2003. This includes the situation where your first date of service occurred electronically. If our first date of service with us was an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

- ☐ I have received a copy of the Privacy Notice of LHHC
- ☐ LHHC has offered me a copy of the Privacy Notice with I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

Signature X_____Date:_____

Additional Person(s) Authorized to make the use or disclosure of my PHI
We at LHHC value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any significant other with our written consent). If you want anyone other than your referring physician to have access to your medical information please list their name(s), and relationship(s) below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)
Name_____Relationship_____
Name_____Relationship_____
Signature X_____Date:_____

Witness Signature
The Staff of LHHC complete this section of Acknowledgement Form is not signed by the Patient:

1. Does the Patient have a copy of the Privacy Notice? Y or N
2. Please explain why the patient was unable to sign an acknowledgment form and our efforts in trying to obtain the Patient signature:_____

Employee Signature:_____Date_____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ **Patient DOB:** _____

Person/Organizations providing the information:

Person/Organizations receiving the information:

_____

_____

Please initial the category of information that you wish to be released:

____Record of attendance and participation in program activities

____Treatment recommendations

____Assessment results and history

____Medical Information

____Psychological examination

____Frequency and results of urinalysis tests

____Other specific information: _____

Method of releasing the information: (Please initial all that apply)

____Telephone ____Written ____Face to Face, in person ____Facsimile

I understand and agree that:

*my behavioral healthcare service/treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations;

*this authorization is voluntary;

*my health information may contain information created by other persons or entities including

health care providers and may contain medical, pharmacy, dental, vision, mental health,

substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;

* I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;

my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;

* this authorization will expire on __/__/__ (MM/DD/YY). I may revoke this authorization at any time by notifying in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

_____

Printed Name of Patient

_____ _____

Signature of Patient **Date**

You may refuse to sign this authorization.

This is not a consent to be treated or for payment of services.