Family & Youth Institute, LLC

26009 Budde Road, Suite A100
The Woodlands, Texas 77380
Office: 281-748-0233 | Fax: 832-481-6495

BIOPSYCHOSOCIAL HISTORY

CLIENT NAME: _____ DATE OF BIRTH: _____

PLEASE COMPLETE THIS FORM AS DETAILED AS POSSIBLE. THIS WILL HELP YOUR THERAPIST GET TO KNOW YOU BETTER AND PREPARE FOR YOUR FIRST SESSION.

What led you to seek counseling?

MEDICAL

Do you have any medical conditions? Please list.

Are you taking any medications? Please list medications and dosages.

What is your current sleep pattern? _____

EMOTIONAL

Have you ever been given any mental health diagnoses? If so, what? ◯ Yes ◯ No

_____

Have you ever had any mental health hospitalizations? ◯ Yes ◯ No

DATE	LOCATION	DAYS IN TREATMENT

Do you have a history of suicide attempts? ◯ Yes ◯ No
Do you have a history of suicidal ideation? ◯ Yes ◯ No
Are you currently feeling suicidal? ◯ Yes ◯ No

Are you experiencing any of the following emotional concerns?

- ☐ Depressed Mood
- ☐ Frequent crying spells
- ☐ Lack of energy
- ☐ Frequent irritability
- ☐ Problems concentrating
- ☐ Lack of motivation
- ☐ Little interest or pleasure in activities
- ☐ Weight change
- ☐ Feeling worthless
- ☐ Hopelessness
- ☐ Panic attacks
- ☐ Constant worry
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Thoughts of death
- ☐ Hyperactivity
- ☐ Mood swings
- ☐ Easily frustrated
- ☐ Disorganized thoughts
- ☐ Impulsive
- ☐ Lethargic
- ☐ Trouble sleeping

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SUBSTANCE USE

Please list any substances you are using or have used in the past.

SUBSTANCE	AGE OF FIRST USE	QUANTITY USING	FREQUENCY OF USE

Please list any substance use treatment you've had.

DATE	FACILITY NAME	DAYS IN TREATMENT	DAYS SOBER	TYPE OF TREATMENT
				◯ Detox ◯ Inpatient ◯ Outpatient
				◯ Detox ◯ Inpatient ◯ Outpatient
				◯ Detox ◯ Inpatient ◯ Outpatient
				◯ Detox ◯ Inpatient ◯ Outpatient

Please List any life experiences related to your substance use.

- ☐ Hangovers
- ☐ Overdose
- ☐ Binges
- ☐ Blackouts
- ☐ Shakes / DTs
- ☐ Seizures
- ☐ Liver disease
- ☐ Increased tolerance
- ☐ Sleep problems
- ☐ Trouble with work / school
- ☐ Trouble with relationships
- ☐ DUI
- ☐ Arrest or jail

FAMILY HISTORY

Who raised you? ◯ Parents ◯ Grandparents ◯ Friends ◯ Guardians ◯ Other relative ◯ Not listed

Have there been any traumatic events that impacted you as a child? ◯ Yes ◯ No

Did you ever receive any counseling for these traumatic events? ◯ Yes ◯ No

In the last year, have you been hit, slapped, kicked, or otherwise abused by anyone close to you? ◯ Yes ◯ No

What is your marital status? ◯ Single ◯ Married ◯ Divorced ◯ Widow(er) ◯ Domestic Partnership

Do you have any children? ◯ Yes ◯ No

CHILD NAME	CHILD AGE	LIVING WITH YOU
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No

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FAMILY MEMBER	LIVING OR DECEASED	LEVEL OF CONTACT	HISTORY OF SUBSTANCE USE	HISTORY OF MEDICAL CONCERNS	HISTORY OF MENTAL HEALTH DIAGNOSES
MOTHER	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
FATHER	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
SIBLING 1 _____ NAME	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
SIBLING 2 _____ NAME	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
SIBLING 3 _____ NAME	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
CHILD 1 _____ NAME	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
CHILD 2 _____ NAME	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
CHILD 3 _____ NAME	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
MATERNAL GRANDMOTHER	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
MATERNAL GRANDFATHER	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
PATERNAL GRANDMOTHER	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
PATERNAL GRANDFATHER	◯ Living ◯ Deceased	◯ None ◯ Frequent ◯ Infrequent	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

SOCIAL

What is your ethnic background? _____

What are your spiritual beliefs? _____

What is your highest level of education? ◯ Less than High School ◯ High School ◯ Graduate ◯ Postgraduate

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Are you currently employed? ○ Yes ○ No

If no, date of last employment? _____

Are you / were you happy with your job / career? ○ Yes ○ No

Have you ever served in the military? What branch? ○ Yes ○ No Branch _____

Do you have any history of legal concerns? If so, what? ○ Yes ○ No

Legal concerns _____

What is your current financial situation? ○ Stable ○ Unable to pay bills ○ Homeless ○ Other

With whom do you live? ○ Spouse / Partner ○ Parents ○ Alone ○ Friends ○ Other

Is your living environment conducive to social and emotional support? ○ Yes ○ No

Are you experiencing any of the following social concerns?

- ☐ Friends that use substances
- ☐ Isolating
- ☐ Anxiety makes it hard to meet people
- ☐ Lack of time with friends
- ☐ Lack of time with family
- ☐ Trouble at school / work
- ☐ Lack of hobbies
- ☐ Over engagement in video games
- ☐ Overspending
- ☐ Binge eating
- ☐ No current social support
- ☐ Lack of physical activity

What are your strengths and weaknesses? _____

What are your hobbies? _____

What are your goals for your treatment? _____