Biopsychosocial/Spiritual Integrated Screening/Assessment Intake

Client First, Middle Initial, Last Name:			Date:	
Address, City, State, Zip:			Age:	Sex:
Marital Status: ☐Married ☐Divorced ☐Separated ☐Legally Separated ☐Unmarried ☐Widowed ☐Registered Domestic Partner				
Date of Birth:	Birthplace:	Race/Ethnicity:	SSN:	
Preferred Phone#(s):(#1)(___) ☐home/☐work/☐cell		(#2)(___) ☐home/☐work/☐cell		
Where may I leave messages? ☐#1 ☐#2 Where may I text? ☐#1 ☐#2	May I contact you by email? ☐ No ☐ Yes Email address:			
Insurance Program/Plan (Provide **card**): **N/A**		ID#:**N/A**	Group/FECA#: **N/A**	
Employer/School:	Address, City, State, Zip:			
Client Employer/School Phone:	Occupation:		☐Full ☐Part Time?	
Active Military *USA* ☐ServiceMember☐FamilyMember *Overseas*☐SM☐FM ☐Leave of absence ☐Retired ☐Terminated				
Check one: ☐FT student ☐PT student ☐Not student	Prior Authorization Number:			
Other health insurance (Member name, policy/group#, DOB, Sex, Employer/School, Ins Plan, relationship to insured, type, SSN, carrier Name, carrier ID):**N/A**				
IF NOT SELF; Sponsor/Insured's First, Middle Initial, Last Name:			Phone:	
Address, City, State, Zip:			DOB:	Sex:
Insured's Employer/School:	Insured's Employer/School Phone:			
Address, City, State, Zip:			☐Full ☐Part Time?	
Occupation:	Relationship to Client:			
If client is child, marital status of parents: ☐Married (Either parent consent:				
Emergency Contact Name:	Phone:	Address:		
Primary Care Physician/PCM:	Phone:	Address:		
Hospital Name:	Phone:	Address:		
Other current provider(s):	Could we coordinate care? ☐No ☐Yes, Phone:			
Previous practitioners and treatment dates:	Therapeutic interventions and responses: What was/was not helpful about it?			
Medication(s) Name, Dosage, Purpose:		Initial Rx date, refill dates:		
Prescribing Physician:		Are you using them as prescribed? ☐No ☐Yes		
Medical conditions:				
Current height:	Weight:	Any accidents:		
Laboratory results:	Psychological test results:			
Consultation reports:	Allergies/Sensitivities:			
Did someone refer you? ☐No (how practice found):		☐ Yes, who:		
Therapy goal:	Who you want to attend therapy with you:			
Any **problems** with: ☐anger/aggression ☐anxiety ☐appetite ☐cognitive impairment ☐decreased energy ☐delusions ☐depression ☐dissociation ☐homicidal thoughts ☐elevated mood/mania ☐hallucinations ☐hopelessness ☐helplessness ☐hyperactive ☐impulsivity/reckless ☐insight/judgment ☐obsessions/compulsions ☐oppositional defiance ☐orientation/memory problems ☐panic attacks ☐paranoia ☐poor concentration ☐pressured speech ☐severe mood swings ☐sleep disturbance ☐somatic complaints ☐agitation ☐irritability ☐disorganized speech ☐ADLs ☐Assertiveness ☐Sadness ☐Grief/loss ☐Job/School Performance ☐Loneliness ☐Shyness ☐Guilt ☐Self-esteem ☐Thoughts ☐Nightmares ☐Stress ☐Self-harm ☐Friends/Social/Relationships ☐Family ☐Parents ☐Past events ☐Divorce ☐Separation ☐Marriage ☐Premarital ☐Dating ☐Miscarriage ☐Abortion ☐In-laws ☐Infertility ☐Parenting ☐Infidelity ☐Sexuality ☐Gender Identity ☐Eating disorder ☐Fears:				

Circle items causing MOST difficulty.				
When did you first experience symptoms related to this visit?				
Have you ever seriously contemplated suicide? □ No □ Yes	Suicide attempted? □No □Yes: #attempts, dates:			
Psychiatric hospitalization #, Dates, Diagnosis, Treatment:				
Current suicidal ideation? □Never □Sometimes □Often □Daily; Imminent risk of harm/elopement potential: □No □Yes:				
Have you experienced **physical** violence? □ No □ Yes (event, when, response):				
Have you experienced **verbal** abuse? □ No □ Yes:				
Strengths:	Weaknesses:			
Spiritual or religious beliefs:	Interests, hobbies, and activities:			
Who is important in your life?				
Education history:	Occupational history:			
Legal history: □DHS Income Supports/□Child Protection, □Youth Diversion, □Criminal Justice/□Probation, □Substance Abuse Arrests and/or □Treatment, □Domestic Violence Intervention Victim Services/□Offender Treatment, □Veteran's Services, □Corrections History/□Parole/□Community Corrections/□Reentry, □Foster Care:				
Bridget Ballard-Cummins, MA, MFT, RP, CSD, Unlicensed Psychotherapist, 2020 N. Academy, Suite 265, Colorado Springs, CO 80909, (719) 332-1246, ballardcummins@hotmail.com				

Family History

Members of Household: Name	Age	Gender	(Biological, adopted, foster, step, etc.)? Special needs?

Do you have family members not currently living with you? □No □Yes; How often do you see them or contact them?

Name	Age	Gender	(Biological, adopted, foster, step, etc.)	Location

Partner's occupation:	Length of relationship:
Describe your partner's personality:	
How do you resolve conflicts or differences?	
If previously married, please complete the following:	

1st marriage: Date married:	Date ended:	Ex-spouse's name:
Children: □ Yes □ No	Reason for divorce:	
2nd marriage: Date married:	Date ended:	Ex-spouse's name:
Children: □ Yes □ No	Reason for divorce:	

Father □ Living, Age:	Occupation:	Health:
□ Deceased, Cause:		Your age at the time of his death:
Describe your father's personality:		
Mother □ Living, Age:	Occupation:	Health:
□ Deceased, Cause:		Your age at the time of her death:
Describe your mother's personality:		

Brothers:	Ages:
Sisters:	Ages:
Describe your relationship with your brothers and sisters:	
Describe your childhood home atmosphere:	
Religious or cultural/ethnic upbringing:	
If not raised by your parents, who did, and when?	
Family members with alcoholism, epilepsy, or a "mental disorder"? □No □Yes:	
Developmental history (physical, psychological, social, intellectual, academic): Delayed/Normal/Early	
Prenatal and perinatal events: Premature/Complications/Healthy/Natural/C-section/Problems:	
Health problems during childhood/adolescence?	
List Illnesses/hospitalizations/surgery dates/reason:	
Substance use: Use of Alcohol: □ Daily □ Weekly □ Monthly x _____ # Years Quantity: Last Use: □ Abstinent	
Tobacco: □ Daily □ Weekly □ Monthly x _____# Years Quantity: Last Use: □ Abstinent	
Caffeine: □ Daily □ Weekly □ Monthly x _____ # Years Quantity: Last Use: □ Abstinent	
Use of Substances (Marijuana, Cocaine, LSD, Prescription/OTC Drugs, Crystal Meth, Heroine, Ecstasy, Other: □ Yes □ No	
Other: □ Daily □ Weekly □ Monthly x _____ # Years Quantity: Last Use: Substance:	
Have you been arrested for driving under the influence? □No □Yes Date(s):	
Has anyone said your drug/alcohol use is a problem? □ No □ Yes: How personality changes when using?	
Has your behavior become more hostile or caused conflict when under the influence of drugs/alcohol? □No □Yes	
Have you had times you cannot remember, the day after you have used drugs/alcohol? □No □Yes How often?	
Have you received substance abuse treatment? □No □Yes, Dates, Where, Outcome: Have you tried to quit? □No □Yes, Outcome:	
Sex History Parental attitudes toward sex (e.g. instruction or discussion?)	
Are you sexually active? □ No □ Yes If yes, when did you first become sexually active?	
Any anxiety or guilt with sex? □ No □ Yes: Is your present sex life satisfactory? □Yes □No:	
Have you experienced sexual abuse?(*fondling, inappropriate remarks, witnessing adults display sexual behavior, lack of privacy in home, coercion by adults to participate in sexual games, being "checked out" to see if you are developing "properly", having sex, or intrusive touching etc.)*□ No □ Yes (circumstances, people involved, response action):	