



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

Table with 3 columns: 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



# Family & Youth Institute, LLC

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

## 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
				<input type="checkbox"/> Detox <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
				<input type="checkbox"/> Detox <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
				<input type="checkbox"/> Detox <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
				<input type="checkbox"/> Detox <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient

Please List any life experiences related to your substance use.

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Hangovers    | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Trouble with work / school |
| <input type="checkbox"/> Overdose     | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Trouble with relationships |
| <input type="checkbox"/> Binges       | <input type="checkbox"/> Increased tolerance | <input type="checkbox"/> DUI                        |
| <input type="checkbox"/> Blackouts    | <input type="checkbox"/> Sleep problems      | <input type="checkbox"/> Arrest or jail             |
| <input type="checkbox"/> Shakes / DTs |  |   |

## 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
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No



# Family & Youth Institute, LLC

26009 Budde Road, Suite A300

The Woodlands, Texas 77380

Office: 281-748-0233 | Fax: 832-481-6495

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

■ Service Location: 26009 Budde Rd., Suite A300, The Woodlands, TX 77380 ■ Mail: 4010 Donalbain Dr, Spring, TX 77373

■ Office: 281-748-0233 ■ Fax: 832-481-6495 ■ Email: [info@familyandyouthinstitute.com](mailto:info@familyandyouthinstitute.com)

■ Website: [www.familyandyouthinstitute.com](http://www.familyandyouthinstitute.com)



# Family & Youth Institute, LLC

26009 Budde Road, Suite A300  
The Woodlands, Texas 77380  
Office: 281-748-0233 | Fax: 832-481-6495

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?

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

What are your strengths and weaknesses? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

What are your goals for your treatment? \_\_\_\_\_