Franciscan Community Counseling
BIOPSYCHOSOCIAL HISTORY INFORMATION

Name: ____ **Date:** ________________________

Physical/Mental Health

Current physical health: Good ☐ Fair ☐ Poor ☐

Is there any history of the following in the family?

☐ thyroid problems
☐ cancer
☐ diabetes
☐ headaches
☐ heart disease
☐ high blood pressure
☐ head trauma

Medications currently being taken:

Medication	Dosage	Frequency	Started	Prescriber	Treatment For	Side Effects
__________	_______	_________	______	_________	_____________	____________
__________	_______	_________	______	_________	_____________	____________
__________	_______	_________	______	_________	_____________	____________
__________	_______	_________	______	_________	_____________	____________

Have you had any prior outpatient psychotherapy/counseling? Yes ☐ No ☐

If yes, provider name: _______________________________ ___ Date: _____________________
Diagnosis (if known): ___________________________________

Have you had any prior inpatient treatment for mental health? Yes☐ No ☐

If yes, facility name: ____________________________________ Date: _____________________
Diagnosis (if known): ___________________________________

Are there any risk factors? Yes ☐ No ☐
☐ homicidal ideation/plan/means
☐ suicidal ideation/plan/means
☐ grave disability
☐ previous suicide attempts
If so, when? ________________________________ Means: _____________________

How is your sleep? _________________________________
Average hours: ___________
Do you suffer from insomnia? Yes ☐ No ☐
If so, do you have difficulty falling asleep? Yes ☐ No ☐
Do you have difficulty staying asleep? Yes ☐ No ☐
Do you wake up too early and cannot go back to sleep? Yes ☐ No ☐

What is your diet like? ________________________________
What foods do you usually eat? ________________________________
What beverages do you usually drink? __________________________

Have you had any significant weight gain or loss? ________________________
If so, how many pounds? _______________

Do you do any exercise? Yes ☐ No ☐
If so, what kind of exercises? ______________________________
How often do you exercise per week? ___________________

Substance Usage:
Have you used any of the following substances?
If so, are you currently using the substance? How much and how often?
☐ Alcohol amount: ________________ frequency: _________________
☐ Amphetamines amount: ________________ frequency: _________________
☐ Barbiturates amount: ________________ frequency: _________________
☐ Cocaine amount: ________________ frequency: _________________
☐ Hallucinogens amount: ________________ frequency: _________________
☐ Inhalants amount: ________________ frequency: _________________
☐ Marijuana amount: ________________ frequency: _________________
☐ Nicotine/cigarettes amount: ________________ frequency: _________________
☐ PCP amount: ________________ frequency: _________________
☐ Prescriptions amount: ________________ frequency: _________________
☐ Other amount: ________________ frequency: _________________

Treatment History of Substance Abuse:

☐ outpatient
☐ inpatient
☐ 12-step program
☐ stopped on own
☐ other ___________________________

Occupational History/Training:

____

____

____

____

Present Stressors:
☐ Relationship
☐ Educational
☐ Occupational
☐ Housing
☐ Economic
☐ Access to Service
☐ Legal/Law Enforcement
☐ Other ____

Trauma History

Have you witnessed a crime and/or violence? Yes ☐ No ☐
If yes, please describe: ____

Have you been the victim of a crime or violence? Yes ☐ No ☐
If yes, please describe: ____

Do you have history of other trauma, sexual abuse, and/or physical abuse? Yes ☐ No ☐
If yes, please describe: ____

What do you believe are your strengths, abilities and positive qualities?

____

Any additional information you would like your therapist to know:

____