Cornerstone Christian Counseling

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BIO-PSYCHO-SOCIAL ASSESSMENT

IDENTIFYING INFORMATION

Referral Source: ☐ Self ☐ Schools ☐ CYFD ☐ Court Ordered ☐ Physician ☐ Internet ☐ Other:

Client Legal Name:	Date of Birth:	Do you identify as: ☐ Male ☐ Female
Preferred Name:	Primary Language:	Religion:

Race/Ethnicity: ☐Anglo ☐ LatinX ☐ Native American ☐ African American ☐ Asian ☐ Other:

Client is: ☐ Minor Child ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

FAMILY INFORMATION (IF CLIENT IS A MINOR CHILD)

Family Structure: ☐ "Traditional" ☐ Blended ☐ Adoptive Parent ☐ Foster Parent ☐ Shared Custody

If parents are separated/divorced who has legal rights to consent for treatment? _____

Is there a Parenting Plan or court documentation? ☐ Yes ☐ No (If yes, please provide a copy for your client file).

Is there another person who is legally required to consent to your child's treatment? ☐ Yes ☐ No

If yes, who: _____ Phone: _____

Address: _____
Street State Zip Code

WHY ARE YOU SEEKING SERVICES

Please explain why you are seeking services:

Are there any specific events or stressors that you would like your therapist to know about?

RISK FACTORS

Emotionally / Physically / Sexually Abused (please circle all that apply)	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Emotionally / Physically / Sexually Abusive to others (please circle all that apply)	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Child Protective Services Involvement	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Criminal History / probation / legal difficulties (circle all that apply)	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Neglect	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Domestic Violence	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Family Conflict	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Homelessness	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Homicidal	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Academic Performance Issues	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Cutting	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Developmental Delays	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Difficulty Paying Attention	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No
Sensitive to Touch, Sound, Light, Motion	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No

Loss of a Loved One	☐ Yes	☐ No	Within last year?	☐ Yes	☐ No

MEDICAL CONDITIONS / HISTORY

Condition:	When:
Treatment:	
Condition:	When:
Treatment:	
Allergies:	
Notes:	

PAST PSYCHIATRIC HISTORY

Prior treatment: Yes ☐ No ☐	Where:	Diagnosis:
Hospitalization: Yes ☐ No ☐	Suicide Attempt: Yes ☐ No ☐	Violence History: Yes ☐ No ☐
Notes (**including family history**):		

CURRENT MEDICATIONS

Medication:	Dose:	Prescribing Physician:
Purpose of medication:		
Medication:	Dose:	Prescribing Physician:
Purpose of medication:		
Other:		

SUBSTANCE USE

Alcohol: Yes ☐ No ☐	What age did you start:	Frequency:
Other Substances: Yes ☐ No ☐	What:	
What age did you start:	Frequency:	Last use:
Notes (**including family history**):		

EMOTIONAL/EDUCATIONAL/OCCUPATIONAL HISTORY

Please Describe Individuals that live in your household:

Name	Date of Birth	Relationship	Description of Relationship (i.e. positive, stressful, cut-off, etc.)

Please describe any relationships with friends or family that you feel are important to share with your therapist:

What are your / your child's personal strengths:

Any stressors at or about school:

Stressors or issues at work affecting you / your family:

Do you feel there are any limitations or barriers to you seeking services?

GENERALIZED ANXIETY DISORDER SCALE (GAD 7)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Clinician Use: Score

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching tv	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Clinician Use: Score

PHQ-A EXTENDED QUESTIONS FOR CHILDREN AND ADOLESCENTS

In the **<u>past year</u>** have you felt depressed or sad most days, even if you felt okay sometimes? ☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐Yes ☐No

SIGNATURE

Client/Parent/Guardian's Signature

Date

FOR PROVIDER USE: INITIAL DIAGNOSIS

Initial Diagnosis/ICD-10 Code: _____ / _____

Treatment Recommendations: _____

_____

_____

_____

Intake Notes:

Clinician's Signature & Credentials

Date