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BIOPSYCHOSOCIAL ASSESSMENT FORM

Today's Date: _____ Name: _____
(Last), (First) (Middle)

Instructions: To assist me in helping you, please fill out this form as completely as you can so that we can save time during our first session together. The information you provide is confidential and no one but me has access to it without your permission.

Date of Birth: _____ Age: _____ Sex: M _____ F _____

Address: _____

Email Address: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Please indicate whether I may leave messages at any of the above phone numbers: _____

Emergency Contact Name (please note relationship): _____ Phone #: _____

What occupation (s) have you mainly been trained for? _____

Present Occupation: _____ Place of Work: _____

Spouse's Occupation: _____ Place of Work: _____

Years of Formal Education completed (circle number of years): 1 2 3 4 5 6 7 8 9 10 11 12 (High School) 13 14 15 16 17 18 19 20+

Insurance Co: _____ Policy #: _____ Group #: _____

Address for Claims: _____

Phone # for Claims: _____

How were you referred to me? (circle) Friend _____ Relative _____ Doctor _____ Phone Book _____
Other: _____

May I contact the person who referred you to me? Yes _____ No _____

Present Marital Status (circle): Never married _____ Married now for 1st time _____ Married now for 2nd (or more) time _____
Separated _____ Divorced and not remarried _____ Widowed and not remarried _____

Number of years married to present spouse: _____

Ages of male children: _____ Ages of female children: _____

Mother's age: _____ If deceased, how old were you when she died? _____

Father's age: _____ If deceased, how old were you when he died? _____

If your mother and father were separated or divorced, how old were you at the time? _____

Mother's occupation (or former occupation): _____ Father's occupation (or former occupation): _____

Briefly describe the type of person your mother (or stepmother or mother-figure) was when you were a child and how you got along with her:

Briefly describe the type of person your father (or stepfather or father-figure) was when you were a child and how you got along with him:

Number of living brothers: _____ Ages of living brothers: _____

Number of living sisters: _____ Ages of living sisters: _____

I was child number _____ in a family of _____ children. Were you adopted? (circle) Yes No

How religious OR spiritual are you? (Circle number on scale that best approximates your degree of religiosity and/or spirituality):

Very Average Atheist
1 2 3 4 5 6 7 8 9 10

BRIEFLY list (print) your present main complaints, symptoms, and problems that bring you to therapy:

Under what circumstances are your problems worse?

Under what circumstances are they improved?

List your main strengths:

List your main weaknesses:

List your main life goals:

List the things about yourself you would most like to change:

Please list the people/groups who are of support to you, currently:

What kind of treatment have you previously had for emotional problems? Please check all that apply and provide a brief description of the provider of treatment, the dates or length of treatment, and treatment outcomes.

_____ Individual therapy
Provider(s): _____
Dates of Treatment: _____
Treatment Outcomes (Was it helpful? Why?) _____

_____ Group therapy
Provider(s): _____
Dates of Treatment: _____
Treatment Outcomes (Was it helpful? Why?) _____

_____ Psychiatric hospitalization
Provider(s): _____
Dates of Treatment: _____
Treatment Outcomes (Was it helpful? Why?) _____

Are you undergoing therapy treatment anywhere else, now? (circle) Yes No

List any physical ailments, diseases, complaints or disabilities:

List any medications you are taking:

Have you or anyone in your family suffered from psychiatric illness? Please explain:

Has anyone in your family committed suicide or attempted suicide? List dates and relationship:

Have you ever been physically, sexually or emotionally abused by someone else? Please briefly explain:

Have you ever physically, sexually or emotionally abused another person? Please briefly explain:

How many alcoholic beverages do you consume:

_____ Per day _____ Per week _____ Per month

How many caffeinated beverages do you consume:

_____ Per day _____ Per week

Have you used in the past or do you presently use illicit drugs, prescription sedatives or painkillers? If so, list the type of drug used in the past year, approximate dates used, amount used, and frequency of use (write on the back of this page if needed):

Do you feel that you have a problem with drug or alcohol use? (circle) Yes No

Have you ever had or do you currently have legal problems? Please describe:

Please list any additional information that you think might be helpful to include (use the back page if needed):

FOR THERAPIST'S USE ONLY

Diagnosis/Diagnoses:

1. Axis 1:
2. Axis 2:
3. Axis 3:
4. Axis 4:
5. Axis 5 GAF:

Therapist's Signature: _____

Date/s Reviewed with Client: _____