Avenues to Recovery Inc.
Bio-Psychosocial Assessment

Name_____ email:_____
Address_____ Sex: __Male __Female
City _____ referral_____
Phone_____
Age_____DOB_____ SSN_____

Emergency Contact:_____phone_____
Relationship to client_____ health professional:_____
Case manager_____

Present Marital Status: __single __divorced __widowed___separated___married

Ethnic Background: __caucasian __black __hispanic ___asian__native american
Spouse Background: __caucasian __black __native american __hispanic

Spouse information:
Name:_____Age____DOB____Sex: __male __female
Street_____Phone_____
City _____Zip_____
Is spouse employed __yes__no Employer:_____
Was spouse previously married __yes __no

Children Information: Number of children __Hers __His __Ours

Name	Age	Sex

Family Background: Parents: __Natural __Foster__ Other_____

Mother's Name_____	Father's Name_____
Street _____	Street _____
City _____	City _____
Phone _____	Phone _____
Age _____	Age _____

Present marital status: __married __divorced __widowed __separated
Sibling Information: Name Age Sex

_____
_____
_____
_____

Do any of the family (parents, siblings spouse children) have a chemical dependency problem? If so, specify who and what they have abused. __yes __no _____

What brings you to Avenues to Recovery?

_____
_____
_____
_____

Education Information:

Your educational level: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Vocational/special training __ yes __no (if yes, please specify) _____

Military service __ yes __no (if so, when?) _____

Employment Record: (past 5 years)

Employer	Type of Work	Date of employment	Reason for leaving

Alcohol and Drug History:

	1st choice	2nd choice	3rd choice	4th choice
what				
when started				
How much				
How often				
Feeling stated Before				
After Behavior				
Effect on Relationships				
Longest period Of abstinence				
Last period of Abstinence				
Last use				

Current status and associated problems:

Mental Health History:

Have you ever had thoughts of hurting yourself ____ In the past 10 years? ___
Have you ever had thoughts of hurting someone else? ____ In the past 10 years? ___
(If yes to any of these, please provide further details)

History of:
Physical Abuse ___ yes ____no ____ victim ___ perpetrator
Emotional Abuse ___ yes ____no ____ victim ___ perpetrator
Sexual Abuse ___ yes ____no ____ victim ___ perpetrator

(if yes, please indicate the following)

What was the Incident? Was it reported? Legal authorities involved? Outcome?

Treatment History: chemical dependency (inpatient, outpatient, halfway house, etc)

Name of program where when how long

Spiritual/psycho treatment: (minister, mental health, private therapist, outpatient)

Name of program where when how long

Spiritual Affiliation:

Legal History: Alcohol/Drug Arrest Record:

Charge: Date arrested Date convicted Incarcerated Status

_____

_____

_____

_____

Other arrests:

Charge	Date arrested	Date convicted	Incarcerated	Status

Medical History

Have you or any of your immediate family ever been diagnosed with or been treated for any of the following?

	Yes	no	who		yes	no	who
Diabetes	___	___	_____	High Blood Pressure	___	___	_____
Low blood sugar	___	___	_____	Low blood Pressure	___	___	_____
Heart Problems	___	___	_____	Epilepsy	___	___	_____
Gastritis	___	___	_____	Ulcers	___	___	_____
Pancreatitis	___	___	_____	Depression	___	___	_____

Other

In the past three months, have you had:

	yes	no		yes	no
Trouble sleeping	___	___	Loss of Appetite	___	___
Trouble staying awake	___	___	Fatigue	___	___
			Unusual Pains	___	___
Trouble breathing	___	___	Other	___	___

Previous Diagnosis:

Medications:

Medication	Dosage	Frequency	Still Taking	Allergic Reaction

Do you have any handicaps yes_____ no___(If yes, please list_____

_____

Have you ever been hospitalized? Yes____ no_____ (if yes, complete the following)

Type	when	where	current status

TB Risk Assessment:

1. Have you had contact with someone who has infectious TB disease? _____
2. Were you born in areas of the world where TB is common? (Asia, Africa or Latin America)_____
3. Are you of a low-income group with poor access to health care including those that have been homeless n the past two years?_____
4. Have you injected illicit drugs?_____
5. Have you lived or worked in residential facilities?_____
6. Have you worked in a facility where you may have been exposed to TB?_____
7. Are you at risk of having HIV/AIDS as a result of unprotected sex or shared needles?_____
8. Are you infected with HIV?_____

If the answer is YES to any of above:

Within the past month, have you had any of the following:
Cough within the past 3 weeks? _____
Sputum production or blood with cough?_____
Unexplained loss of appetite or sudden weight loss? _____
Fever, chills, or night sweats? _____
Persistent shortness of breath?_____
Increased fatigue? _____
Chest pain? _____

Current Living Situation/ Support Systems:
Is your home environment safe? _____
Is your home environment supportive of your treatment? _____
Do you have sufficient transportation? _____
Do you have a support system currently in place outside of home? _____
(if yes, whom?) _____

Economic Information:
How many people living at home? _____
Amount of gross income per month? _____

Initial Assessment

Type of Services

Recommendations:

Rationale for Recommendations:

Appropriate Referrals (i.e. Licensed Medical and/or Mental Health Professional)

Collateral Contact Information:

Counselor Signature Date