Recovery Pathways, LLC
Biopsychosocial History

Name ___________________________ Date of Birth. ____/____/______ Soc Sec # _____-____-_______ Date _____/_____/______ Page 1

WHY ARE YOU HERE TODAY?

____

____

RELATIONSHIP STATUS: ○Single ○Significant Other ○Married ○Divorced ○Widowed ○Separated ○Other __________How long? ________

SEXUAL ORIENTATION: I am ○Male ○Female ○Transgender & will have ○Sex Only w/Men ○Sex Only w/Women ○Sex w/Men & Women

DO YOU HAVE CHILDREN: ○Yes ○No **If yes complete the following:** #of boys____ #of girls____ #of biological____ #of step/adopted____

Ages of children:_______________ Is CPS/Foster Care involved? ○Yes ○No If yes, why:_________________________ How many live with you____

If your children live elsewhere, with whom & why?____

HOUSING: ○ Homeless ○ Renting ○Own ○Stay in -○Apartment ○House - ○Alone ○With Parent ○With Partner/Spouse ○With Friends

WORK STATUS:○Employed - For how long?______ Trade or occupation?___________________ ○Seeking a job ○Disability for ______________

EDUCATION: Highest Grade in School _________ ○GED Are you in school now? ○Yes ○No If yes, what for?__________________________

CURRENT SYMPTOM CHECKLIST (Please Check √ below Symptoms or Emotional / Behavior Problems you are currently having)

○ substance abuse	○ frequently daydream	○ generalized anxiety	○ lack of attachment	○ set harmful fires
○ alcohol abuse	○ extreme worrier	○ agitation / nervousness	○ sometimes easily irritated	○ paranoid or blaming ideas
○ worthlessness	○ distrustful of others	○ sudden panic attacks	○ emotional outbursts	○ phobias or unusual fears
○ hopelessness	○ frequently crying or sad	○ hyperactivity	○ behavior problems	○ hallucinate unusual things
○ depressed mood	○ mood swings	○ racing thoughts	○ immature	○ delusional thoughts
○ fatigue or low energy	○ socially isolate yourself	○ interrupt others' words	○ oppositional behavior	○ bowel or bladder trouble
○ slow movements	○ grief or loss of loved one	○ obsessive thoughts	○ aggressive angry outbursts	○ sexual function problems
○ poor grooming	○ increased/decreased appetite	○ compulsive actions	○ cruel to animals	○ chronic pain
○ trouble sleeping	○ recent weight loss or gain	○ chronic lying	○ hostile/angry mood	○ cut or harm yourself
○ indecisive	○ stop eating to lose weight	○ stealing	○ violent temper	○ guilt from previous acts
○ easily distracted	○ binge eat & vomit	○ not trustworthy	○ break things when angry	○ victim of abuse
○ trouble concentrating	○ I think I am overweight	○ disobedient	○ assaults on others	○ abuser of others

MEDICINES: What past/present medicines have been prescribed to you for anxiety, depression, mood swings or ADHD? (Name, dose, frequency, why?)

____

____

What street drugs, substances, or medicines are your primary addictions? (Please list name, dosage, frequency and how you got started)

____

____

Why do you want to stop using these substances or street drugs? ○ I chose on my own ○ Custody Issues ○ Court Ordered ○ Probation or Parole

Please explain:____

____

What drugs did you last use and when? ____

Are you in withdrawal now?____

Have you ever used Suboxone or buprenorphine? Was it off the street or was it prescribed to you? ______________________

What other medicines prescribed to you for other medical conditions are you currently taking? (Please list name, dosage, frequency & why it was started)

____

____

____

Do you have any allergies? ○No ○Yes (describe below)

Allergy:___________________Symptoms:__________________

Allergy:___________________Symptoms:__________________

Describe any car/other accidents, operations, traumatic injuries or hospital stays:

____

____

MEDICAL HISTORY: Describe current general physical health: ○ Good ○ Fair ○ Poor

Who is your family doctor, NP or PA? Name: ____________________________________

City:____________________________________ Phone: ______________________________

When did you last see your family doctor, NP or PA? _______________________________

List any significant medical problems: ____

____

Who is your current therapist or psychiatrist? Name:_______________________________

City:____________________________________ Phone: ______________________________

When did you last see your therapist or psychiatrist?_______________________________

Check √ below if you have a history of the following:

○ heart disease	○ drug abuse
○ diabetes	○ alcoholism
○ hepatitis: A B C	○ HIV positive or AIDS
○ high blood pressure	○ physical trauma or accident
○ tuberculosis	○ birth defects
○ thyroid problems	○ cancer of ______________
○ mental retardation	○ stroke or dementia

EMOTIONAL/PSYCHIATRIC HISTORY:

What other therapists or psychiatrists have you seen in the past for treatment with psychotherapy or for substance abuse?

Prior provider name	City	State	Phone	Diagnosis	When did you start?	When was your last visit?

Have you ever been admitted into an inpatient treatment facility or hospital for a psychiatric, emotional, or substance use disorder?

If yes, how many times: ____ Longest treatment at (Facility name)____________________ from _____/_______(M/Y) to _____/_______(M/Y)

Other inpatient provider name	City	State	Phone	Diagnosis	What kind of treatment?	Did it help?

Have you been diagnosed with a mental health condition? ○Anxiety ○Depression ○Bi-Polar ○ADHD ○Other: ________________

Do you now have suicidal thoughts? ○Yes ○No **If yes, do you have a plan?** ○Yes ○No **Do you want to act on this plan?** ○Yes ○No

What prevents you from acting on these thoughts? ____________________

SUBSTANCE USE HISTORY (Please complete form below for substances used in the past or present)

Substance Use History	Age of First Use	Date of Last Use	If inject IV, Mark with X	Number of days used in last month	Amount used in the last 48 hours	Amount and frequency during the last 6 months	If Prescribed, Mark with X
Nicotine/Cigarettes							
Alcohol							
Excessive Caffeine Use							
Rx Opiates/Methadone							
Benzos/Valium/Xanax							
Marijuana or Hashish							
Heroin							
Speed / Meth / Crank							
Amphetamines							
Spice/Synth Marijuana							
Cocaine							
Crack Cocaine							
Hallucinogens (eg LSD)							
Codeine / Tramadol							
Cough / DM / Corricidin							
Inhalants (glue, fumes)							
Other:							

Drug Abuse History: Have you ever overdosed? ○ Yes ○ No

Did you go to hospital for it? ○ Yes ○ No When? __________

Medical Marijuana Card? ○ Yes ○ No (Not Allowed Here)

Attend support groups (AA/NA/SMART etc.)? ○ Yes ○ No

Ever stopped using all abused substances? ○ Yes ○ No

Consequences of your substance abuse (check all that apply):

○ hangovers ○ withdrawal symptoms ○ sleep disturbance ○ binges
○ seizures ○ lose control of amount ○ child custody problems ○ job loss
○ blackouts ○ tolerance changes ○ suicidal impulse ○ arrests
○ diseases ○ domestic violence ○ relationship conflicts ○ assaults

Do you have people to support your recovery? ○ Yes ○ No Who?____________________

FAMILY HISTORY: Has any family member had a drug/alcohol addiction or mental health condition? ○ Yes ○ No If so, please explain:
____

Are you adopted? ○ Yes ○ No Were you in foster care? ○ Yes ○ No Were your parents incarcerated? ○ Yes ○ No How long? ________

Any other significant family issues/abuse/neglect? ____________________

History of physical/sexual/emotional abuse? ____________________

SOCIO-ECONOMIC HISTORY: Do you have non-substance abusing friends? ○ Yes ○ No Has drug abuse affected jobs? ○ Yes ○ No

RELIGIOUS / SPIRITUAL HISTORY: If applicable, explain any beliefs/affiliations you want to include in treatment: ____________________
____

LEGAL STATUS:

	Yes No		Yes No		Yes No		Yes No
VALID Driver's License	○ ○	Currently on Probation/Parole	○ ○	Previously on Probation/Parole	○ ○	Previously in Prison	○ ○
Lost custody of your kids?	○ ○	Custody issues now with kids?	○ ○	Facing criminal charges now?	○ ○	History of felonies?	○ ○

Explain any above legal problems you are having:____________________
____

Describe any other Legal / Economic / Financial / Social / Family / Occupational/Healthcare Access / Educational issues you are now having:
____
____

Form Completed by ____________________ ○**Patient** ○**Other** **Date** _____/_____/_____