Biopsychosocial Assessment Criteria

Presenting problem – The presenting problem is why they came to see you.

History of Presenting Problem – Include any stressors that contribute to presenting problem what they have tried in the past, how symptoms have progressed, etc.

Developmental – Include any developmental delays, milestones, learning disabilities, include if there were any problems with mother's pregnancy and if she used in utero. Include childhood trauma, physical and sexual abuse, natural disasters.

Medical History – Include present and past medical conditions, medications, dosage, purpose, prescribing physician and allergies. You can include their current health status (good, fair, poor) and information about diet, nicotine and caffeine use, and exercise.

Mental Health History – Present and past, include symptoms, medications, suicidal ideation – when and what, suicidal attempts – when and what, and self-harm – when and what. History of trauma – sexual abuse, verbal abuse, physical abuse.

Social History - information on social support, friends, family and the nature of those relationships. Education – Include their educational history including if they graduated high school and what year. If they didn't, why they didn't graduate. Include any college or trade schools, major and if they finished. Employment – Include their past and current employment and satisfaction with employment.

Legal Involvement – Include any legal issues, probation and probation officer, current and past arrests and the outcome, any convictions and the outcome. You can include any bankruptcy or lawsuits.

Military – Include whether they have ever been in the military. If they have how long they were in it, if they are still in it and what type of discharge. Do they receive Veterans Benefits?

Substance Abuse History– Include any information on substances abused present & past, age of fist use, date of last use, method of use, relapses and if they are in recovery. Please include information on caffeine and nicotine use here. History of treatments – did they complete or not; when and where; and for what length of time.

ASAM Dimensional Breakdown – Individualized for each dimension OVER THE PAST 12 MONTHS

Treatment Recommendations – Identify level of care recommendations and Individualized goals for treatment.

Mental Status – Note whether the client was on time, behavior, attitude, orientation to person, place and time, how was their mood, affect, tone of voice, rate of speech, judgment, memory, suicidal or homicidal ideation and any observable symptoms.

Diagnoses – Past & present – SUD diagnoses qualifying them for treatment. History of any mental health diagnoses and indicate if they are by history or if they are present and have been verified.

Assessment/Clinical Impressions – This is your assessment of the client. Summarize presenting problem and underlying problems, your impression of the client, any themes or patterns you were aware of, strengths, weaknesses, cultural issues, motivation, readiness to change, what made help the client be successful, negative factors that may impact treatment, preferred coping mechanism of client, etc.

Biopsychosocial Assessment Must be signed with the following - Signature with Credentials and Date of the Assessment is required.