**Biopsychosocial Assessment Template**

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| Report Date: |  |
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| Name of person submitting report: |  |
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| Client/Patient name: |  |
|  |  |
| Client/Patient date of birth: |  |
| Date of initial assessment:  |  |

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| Basic Information |
| Gender |  |
| Referred by |  |
| Current situation |  |
| Safety assessment |  |
| Emotional state |  |
| Physical state |  |
| Priority 1 needs(emergency needs) |  |
| Priority 2 needs(urgent needs) |  |
| Priority 3 needs(short-term needs) |  |
| Priority 4 needs(long-term needs) |  |
| Sources of data collection |  |
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| Background & Detailed Assessment Information |
| Individual strengths |  |
| Supports & opportunites |  |
| Identified help resources |  |
| Clinical test scores(e.g. PHQ-9, GAD-7) |  |
| Family composition & history |  |
| Cultural values |  |
| Social circle |  |
| Education |  |
| Past trauma |  |
| Substance use |  |
| Employment history |  |
| Skills |  |
| Leisure activities |  |
| Motivations |  |
| Patterns of crisis |  |
| Criminal history |  |
| Attitudes about money/finances |  |
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| Medical History |
| Is the individual being treated for a physical medical condition? |   Yes  No  |
| If Yes, please describe. |  |
| List any prior illnesses, operations, and accidents the individual has had. |  |
| Is the individual currently taking any prescription medications for physical issues? |   Yes  No |
| If Yes, please list medication and frequency taken. |  |
| List the name of the individual's primary carephysician |  |
| Primary care physician contact details |  |
| Add any additional comments related to the individual's mental health and medical history |  |
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| Impressions, Assessment, Recommendations |
| Clinical summary &assessment |  |
| Targets & goals |  |
| Social worker recommendations |  |
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