Taylor Life Center
Consumer Services, Inc.

Biopsychosocial Assessment –
Initial Assessment

*The words "you" and "your" on this form refer to the consumer receiving treatment—adult or child—not the person completing the form. Please fill out each section as appropriate based on the consumer's age. **A minor is any person age 17 and under. An adult is a person who is age 18 or over with or without a guardian.**

Date of Service: _____

Consumer Name: _____ **Date of Birth:** _____

1. **Name of person completing form** (if other than consumer): _____

   Relationship to consumer: _____

   If a guardian, please identify what type of guardianship*: ☐ Family Guardian ☐ Public Guardian
   **Proof of guardianship/adoption required for treatment*

2. **Physiological Gender:** ☐ Male ☐ Female

3. **Parents/Guardian Information of child consumer:** ☐ N/A **(If consumer is an adult, skip to question #5)**

	Name	Age	Address/Phone	Marital Status
Mother:				
Father:				
Stepmother:				
Stepfather:				
Adopted Mother:				
Adopted Father:				
Guardian:				

   Guardian relationship to child: _____

   DHS papers required.

   DHS Worker: _____

   ☐ Temporary Ward of the Court ☐ Permanent Ward of the Court

4. **With whom does the child live?**

   Name: _____ Age: _____ Relationship: _____

5. **Please check the box that best defines your current living situation:**

   ☐ Homeless on street or in shelter
   ☐ Private residence with family members
   ☐ Private residence: alone, with spouse or with friends
   ☐ Specialized residential home
   ☐ General residential home
   ☐ Prison/Jail/Juvenile Detention Center
   ☐ Support independence program
   ☐ Nursing home
   ☐ Institutional setting
   ☐ Other: _____

   Additional comments on current living situation:

6. If you are living in private residence, please list the name of each member in the residence:

Household Member Name	Relationship	Age	Quality of Relationship

(If consumer is an adult, skip to question #28)

PRENATAL HISTORY ☐ N/A

7. Please describe mother's pregnancy:

☐ Uncomplicated

☐ Complicated by:

Any prescription med, drug or alcohol use? ☐ No ☐ Yes, explain:_____

8. Did the child come to full-term (37-40 weeks gestation)?

☐ Full-term

☐ Pre-term, by how much? _____ (weeks of gestation)

Cause:_____ (premature labor, maternal disease, accident, etc.)

☐ Post-term, how long? _____

9. How was the child delivered?

☐ Natural/Vaginal Deliver

☐ Induced, explain: _____

☐ C-Section, explain: _____

10. Any complications after delivery: ☐ No ☐ Yes (please check all that apply)

☐ NICU ☐ Intubation ☐ Jaundice ☐ Malformation

11. The child's birth weight:_____ (pounds, ounces) and length: _____

12. As an infant, did the child have any diseases or hospitalizations? ☐ No ☐ Yes, explain:

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

DEVELOPMENTAL HISTORY **(If consumer is an adult, skip to question #28)**

13. Please check when the child achieved the following activities:

	On-time	Delayed		On-time	Delayed
Rolled over	☐	☐	Smiled	☐	☐
Sat up without help	☐	☐	Slept all night	☐	☐
Crawled	☐	☐	Ate solid food	☐	☐
Took steps	☐	☐	Spoke words	☐	☐
Walked without assistance	☐	☐	Spoke in sentences	☐	☐
Bladder trained	☐	☐	Bowel trained	☐	☐
Regularly dry at night	☐	☐			

14. As a toddler, did the child have any health issues? ☐ No ☐ Yes, explain:

15. Was the child vaccinated? ☐ No ☐ Yes

16. Please explain any problems child had during infancy (age 0-1)

☐ No problems

17. Please explain any problems child had during preschool (age 2-4)

☐ No problems

18. Please explain any problems child had during childhood (age 5-12)

☐ No problems

19. Please explain any problems child had during adolescents (age 13-17)

☐ No problems

EDUCATION ☐ N/A

20. Please identify child's grade _____ and education needs:

Regular education classroom – no special services: ☐ Yes ☐ No (if no, check all that apply)

☐ Multiple disabilities (not deaf-blind)	☐ Orthopedic impairment	☐ Autism
☐ Deaf blindness	☐ Emotional disturbance (SBH)	☐ Traumatic Brain Injury
☐ Deafness (hearing impairment)	☐ Intellectual Disability	☐ Other health impairment (major)
☐ Visual impairment	☐ Specific learning disability	☐ Other health impairment (minor)
☐ Speech or language development	☐ Preschoolers with a disability	☐ Current 504 Plan

☐ Other: _____

Please provide copy of IEPC/testing

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

21. Please rate child's school attendance:
☐ Excellent ☐ Good ☐ Fair ☐ Poor
Explain:

22. Please best indicate the child's school grades:
☐ Mostly A's ☐ Mostly B's ☐ Mostly C's ☐ Mostly D's ☐ Mostly E's/F's

23. Has child ever been held back a school grade? ☐ No ☐ Yes, please explain which grade(s):

24. Has the child every received a suspension or expulsion from school? ☐ No ☐ Yes, please explain:

25. Do you have school concerns regarding performance or behavioral problems due to alcohol or drug use?
☐ No ☐ Yes, please explain:

26. Does the child have any barriers to learning?
☐ No ☐ Inability to read and write ☐ Other: _____

27. Does the child have any special communication needs?
☐ No special communication needs ☐ Assistive Listening Device(s)
☐ TDD/TTY Device ☐ Language Interpreter Services needed/other spoken language: _____
☐ Sign Language Interpreter ☐ Other Assistive Technology:

(If consumer is a minor, skip to question #33)

28. What is your highest level of education? (Please check all that apply)
☐ Completed less than high school ☐ Currently in school – K - 12th grade ☐ Currently attending college
☐ Completed high school or GED ☐ Currently in training program ☐ College graduate
☐ Completed some college ☐ Currently in special education ☐ Other: _____

29. Do you have a history of learning difficulties? (Please check all that apply)
☐ No ☐ Mental Retardation ☐ Special school placement: _____
☐ Learning disability/type:_____ ☐ Other: _____

30. Do you have any barriers to learning?
☐ No ☐ Inability to read or write ☐ Other: _____

31. What is your primary spoken language? ☐ English ☐ Spanish ☐ Arabic ☐ Other:_____

32. Do you have any special communication needs?
☐ No ☐ TDD/TTY Device ☐ Sign Language Interpreter ☐ Other assistive technology
☐ Assistive Listening Device ☐ Language Intrepreter Services needed/other spoken language: _____

33. Is there anything about your culture you want your therapist to know?
☐ None ☐ Background ☐ Beliefs ☐ Ethnicity ☐ Traditions ☐ Practices ☐ Religion ☐ Sexuality
Please explain:

34. Gender Identification: ☐ Male ☐ Female ☐ Transgendered ☐ Other: _____

35. Gender Expression: ☐ Male ☐ Female ☐ Transgendered ☐ Other: _____

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

36. Sexual Orientation: _____

37. Is there anything about your spirtual beliefs you want your therapist to know? ☐ Yes ☐ No
Please explain:

(If consumer is an adult, skip to question #45)

SOCIAL DEVELOPMENT ☐ N/A

38. How does the child relate to family members?

39. How does the child relate to peers?

40. How does the child relate to authority figures?

41. Does the child have any history of abuse or neglect? ☐ No ☐ Yes, please explain:

42. Please identify any sexual identity issues/concerns: ☐ No problems

43. Is the child sexually active? ☐ No ☐ Yes

44. Is the child currently employed? ☐ No, not pertitnent ☐ Yes

If currently employed, name of employer: _____

Job Title: _____

Employment Interest/Skills/Concerns:

(If consumer is a minor, skip to question #55)

EMPLOYMENT

45. What is your current level of employment? (Please check all that apply)

- ☐ Employed full-time (greater than 30 hrs/week)
- ☐ Employed part-time (less than 30 hrs/week)
- ☐ Unemployed, but looking for work and/or on layoff from job
- ☐ Unemployed, not looking for work (homemaker, student, institutionalized)
- ☐ Sheltered workshop or work services participant in non-integrated setting
- ☐ Retired from work
- ☐ Not working – under 18
- ☐ Volunteer/unpaid work
- ☐ Other: _____

If employed, please write the name of your employer:_____

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

46. Are you satisfied with your current job? ☐ N/A ☐ No ☐ Yes

47. If you are not currently working, do you want to work? ☐ No ☐ Yes

48. Are you experiencing financial problems? ☐ No ☐ Yes

49. Are you concerned employment will affect any financial benefits you are receiving? ☐ No ☐ Yes

50. Have you been involved in supportive employment in the past? ☐ No ☐ Yes

51. Have you been involved in employment workshops? ☐ No ☐ Yes

52. Have you been involved in job coaching? ☐ No ☐ Yes
Additional comments on employment, past or current skills/interests:

53. Have you ever served in the United States military? ☐ No ☐ Yes
If yes, describe branch of service, any pertinent duties, and any trauma experienced during services as applicable.

Type of Discharge (general/honorable/other): _____

Date of discharge: _____

LEGAL STATUS/ISSUES

54. Do you have a legal payee? (Adults only)
A legal payee is someone who receives disability or social security income on behalf of someone who is not capable of managing their benefits.

Name and address of payee: _____
Phone Number: _____

55. What is your current legal status?

- ☐ No legal issues
- ☐ Alcohol/drug related legal problems
- ☐ ATO (Alternative Treatment Order)
  End date of ATO: _____
- ☐ Conditional release
- ☐ Detention
- ☐ Outpatient commitment
- ☐ On probation
- ☐ On parole
- ☐ Awaiting charge
- ☐ Court ordered treatment
- ☐ Other: _____

56. Please list your history of legal charges (current legal charges, convictions, domestic related court problems, adjunctions, detentions or incarcerations and length of detention/incarceration, civil proceedings, and domestic related court problems):
☐ Not applicable/No legal charges

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

Name of probation/parole officer: _____

Address: _____

Phone number: _____

How long on probation/parole: _____

57. Do you have child support enforcement orders? ☐ N/A ☐ No ☐ Yes, please explain:

58. Have you had <u>any</u> involvement in juvenile court (adult consumer – only matters related to child abuse, neglect or dependency)?

Current: ☐ No ☐ Yes Explain: _____

Past: ☐ No ☐ Yes Explain: _____

Name of Caseworker(s): _____

59. Has CPS had any involvement with the family: ☐ No ☐ Yes, please explain:

60. Name of CPS caseworker(s), Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA):

PHYSICAL HEALTH

61. Name of Primary Care Physician: _____

Address: _____

Phone Number: _____

Other prescribing physician: _____

Address: _____

Phone Number: _____

62. Please explain your past medical, physical, psychiatric symptoms. List any physical limitations, illnesses, diagnoses, operations, hospitalizations (include dates), and/or medical concerns. For minor children, please include age with each explanation.

63. Do you have allergies or adverse reactions to any medications? ☐ No ☐ Yes, please list:

Consumer Name: _____

DOB: _____

Staff Name: _____

Case Number: _____

MEDICATIONS

64. Please list or include a copy of your current medications, including prescriptions, over-the-counter, herbal and vitamins: ☐ No medications

Medication	Rationale/ Purpose	Dosage/Route/ Frequency	Prescriber/Date Prescribed	Efficacy	Do you take your medications as prescribed?		
					Yes	No	Sometimes
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

Consumer Name: ____________________

DOB: ____________________

Staff Name: ____________________

Case Number: ____________________

65. Do you feel like your current medications are working? ☐ Yes ☐ No
If no, please explain which medications you feel are not working and why:

66. Please list your past medications: (within the past 12 months)

Psychotropic Medications	Reason for Discontinuation	Efficacy

67. Please explain any past mental health treatment history:

Outpatient mental health: ☐ Not applicable/No treatment

Name of Agency	Dates of Service (From – To)	Clinician Name

Psychiatric Hospitalization/Residential Treatment Facilities: ☐ Not applicable/No treatment

Name of Hospital/Facility	Dates of Service (From – To)	Reason (suicidal, depressed, etc.)

68. Have you been previously diagnosed by a mental health professional? ☐ No ☐ Yes, please explain:

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

Taylor Life Center
Consumer Services, Inc.

Health Screening

***The word "your" herein after refers to the consumer receiving treatment—adult or child—not the person completing the form. Please fill out each section as appropriate based on the consumer's age. A minor is a person age 17 and under.**

Consumer Name: _____ **Date of Birth:** _____

Date: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Sex:** ☐ Male ☐ Female ☐ Transgendered

1. **Please list any specialists that also provide your medical care:**

2. **Hospital of choice:** _____

3. **Please write the <u>most recent date</u> for the following medical appointments:**
   Medical check-up: _____
   Dental check-up: _____ Dentures: ☐ No ☐ Yes
   Eye examination: _____
   Hearing examination: _____

4. **List any illness that seem to run in your family:**

5. **Have you ever lost consciousness?** ☐ No ☐ Yes
   If yes, when: _____ Explain: _____

6. **Do you see your medical doctor on a regular basis?** ☐ No ☐ Yes

7. **Do you have any allergies?** ☐ No ☐ Yes
   If yes, please check as many as apply and list by name:
   ☐ Food ☐ Drugs ☐ Pollen ☐ Other:
   List: _____

8. **List the immunizations you know the child has had, and dates, if known: (Minor consumer only)**

Immunization	Date	Immunization	Date
☐ Mumps		☐ Polio	
☐ Pnuemovax		☐ DT (Tetanus)	
☐ Measles		☐ MMR	
☐ Hepatitis		☐ Other:	

Staff Name: _____
Case Number: _____

9. **How many hours do you sleep each day?**

10. **How much of the following items do you consumer per day/per week?** (check day or week)
Coffee: _____ ☐ Day ☐ Week Pop/soda: _____ ☐ Day ☐ Week Tea: _____ ☐ Day ☐ Week

11. **a. Do you smoke or use tobacco?** ☐ No ☐ Yes
b. Is the child exposed to second-hand smoke in the home? ☐ No ☐ Yes (Minor consumer only)

12. **Were you ever treated for a sexually transmitted infection?** ☐ No ☐ Yes
If yes, please check all that apply:
☐ Syphilis ☐ Gonorrhea ☐ Herpes ☐ HIV/AIDS ☐ Chlamydia ☐ Genital Warts ☐ Hepatitis
Other: _____

13. **Have you ever been diagnosed with any of the following conditions?**
☐ Cancer: Are you in remission? ☐ No ☐ Yes
☐ Organ failure (kidney, liver): Are you on dialysis? ☐ No ☐ Yes
☐ Congestive Heart Failure: Do you wear a pacemaker? ☐ No ☐ Yes
☐ COPD (Emphysema, Chronic Bronchitis) ☐ No ☐ Yes
☐ Tuberculosis ☐ No ☐ Yes Date of treatment: _____

14. **Do you have a heart problem?** ☐ No ☐ Yes (Minor consumer only)
If yes, explain: _____

15. **Are you on a special diet?** ☐ No ☐ Yes
If yes, explain: _____

16. **Do you have difficulty swallowing food or beverages?** ☐ No ☐ Yes
If yes, explain: _____

17. **Check any of the following that apply to you now or in the past:**

Yes	No		Yes	No		Yes	No	
☐	☐	Headaches	☐	☐	Hearing impaired	☐	☐	Chest pains
☐	☐	Dizziness	☐	☐	Blackouts	☐	☐	Heart attack
☐	☐	Fainting	☐	☐	Blurred vision	☐	☐	Stroke
☐	☐	Stomach trouble	☐	☐	Memory loss	☐	☐	Blood clots
☐	☐	No appetite	☐	☐	Sexual problems	☐	☐	Ulcers
☐	☐	Eat too much	☐	☐	Confused thoughts	☐	☐	Hypoglycemia
☐	☐	Constipation	☐	☐	Low blood pressure	☐	☐	Tremors/shaking
☐	☐	Diarrhea	☐	☐	Menstrual problems	☐	☐	Back problems
☐	☐	Shy/sensitive	☐	☐	Anemia	☐	☐	Urinary infections
☐	☐	Sleep too much	☐	☐	Arthritis	☐	☐	Unable to relax
☐	☐	Insomnia	☐	☐	Lacks energy	☐	☐	Wounds (currently open)
☐	☐	Lung problems	☐	☐	Gout	☐	☐	Cholesterol
☐	☐	Bruises easily	☐	☐	Rashes	☐	☐	Thyroid
☐	☐	Hernia	☐	☐	Hot or cold spells	☐	☐	Closed head injury
☐	☐	Concussion	☐	☐	Sinus	☐	☐	Anxiety/panic

Please explain: _____

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____

18. Please list or include a copy of your <u>current medications</u>, including prescriptions, over-the-counter, herbal and vitamins: ☐ No medications ☐ Copy of medications attached.

Medication	Rationale/ Purpose	Dosage/Route/Frequency	Prescribed by/ Date Prescribed	Do you feel like your medications are working?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If you said no to any medication, please list the medication and explain why it isn't working for you.

19. Please list your <u>past medications within the last 12 months</u>, including prescriptions, over-the-counter, herbal and vitamins: ☐ No medications

Medication	Rationale/ Purpose	Dosage/Route/Frequency	Prescribed by/ Date Prescribed	Date you stopped taking medication	Reason for stopping medication

20. Health Conditions (Please check all that apply)

Hearing (Ability to hear with hearing appliance normally used)

☐ Adequate ☐ Minimal difficulty ☐ Moderate difficulty ☐ Severe difficulty ☐ No hearing

Hearing aid used: ☐ No ☐ Yes

Vision (Ability to see with glasses or with other visual appliance normally used)

☐ Adequate ☐ Minimal difficulty ☐ Moderate difficulty ☐ Severe difficulty ☐ No vision

Visual appliance used: ☐ No ☐ Yes

Pneumonia

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Asthma

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Upper Respiratory Infections (RESP)

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.

☐ Information unavailable ☐ Other: _____

Consumer Name: _____

DOB: _____

Staff Name: _____

Case Number: _____

Gastroesophageal Reflux (GERD)

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.
☐ Information unavailable ☐ Other: _____

Chronic Bowel Impactions

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.
☐ Information unavailable ☐ Other: _____

Seizure Disorder or Epilepsy

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.
☐ Information unavailable ☐ Other: _____

Progressive neurological disease (Alzheimer's/Dementia, etc.)

☐ Not present ☐ Treated for condition within past 12 mos. ☐ Information unavailable
☐ Other: _____

Diabetes ☐ Type 1 ☐ Type 2

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.
☐ Information unavailable ☐ Other: _____

Hypertension

☐ Never present ☐ History/not treated within past 12 mos. ☐ Treated for condition in past 12 mos.
☐ Information unavailable ☐ Other: _____

Obesity

☐ Not present ☐ Medical diagnosis of obesity present or Body Mass Index (BMI) > 30
☐ Other: _____

21. Do you have any medical need currently requiring attention? ☐ No ☐ Yes

If yes, explain: _____

Client/Guardian Signature: _____ Date: _____

Medical professional review and comments/recommendations:

Medical professional signature: _____ Date: _____

OR

Clinician signature: _____ Date: _____

☐ Based on self-report, a referral for a Physician Health Assessment will be made to: _____

☐ Based on self-report, a referral to a health care practitioner will be made.

Consumer Name: _____
DOB: _____
Staff Name: _____
Case Number: _____