Anxiety Treatment Center of Orlando
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719 Peachtree Road
Orlando, Florida 32806
407 925-6759

Adult Biopsychosocial Assessment

Please answer the following questions honestly to the best of your ability. If you are unable to answer, pls put a notation (*) & write that you prefer to answer in person or later.

Name: ____

DOB:______________________________Age:_______

Address:____

Home phone:_______________Cell:_________________________

Employer:____________________________Occupation:__________________

Work Phone: _______________________________

Highest Grade Completed:______________________________________

Name of School Last Attended:__________________________________

Family-

Are You: Single Married In Significant Relationship Widowed

Spouse/Partner's Name:____

How long have you been together?:____________________

If Divorced/Separated or Widowed, how long?:__________________________

Children & Ages:____

____

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Parents name and age (if deceased, date ofdeath & cause):
*Please also include any history of physical or mental illness

Mother:________________________ Father:

Step Parents:______________________

____

Siblings names and ages (if deceased, date of death & cause):
*Please also include any history of physical or mental illness

Purpose of seeking counseling:

How long has this been a problem for you?:

Present state of health (include hospitalizations, surgeries and all medications:
*Please list all medications, over the counter and prescription, dosage, who is prescribing them - continue on back if necessary

Name and phone number of primary care doctor:

Social hobbies, interests and support system: ____

____

____

Psychiatric history (Please include previous psychotherapy, medications, hospitalizations and suicide attempts) :
*Please include whether you felt the therapy/treatment was successful

____

____

____

Family history: ____
*parent/sibling relationships, history of sexual, physical abuse or anything you feel is important to share

____

____

____

Garrido, Jenifer A., LCSW Page 4 Name: ______________________

Please rate your overall satisfaction in the following areas of your life using this scale:

1	2	3	4	5
Poor	Somewhat Satisfied	Average	Great	Excellent

1. Satisfaction with your career ____________
2. Satisfaction with your body/weight ____________
3. Satisfaction with yourself overall ____________

   *Self Esteem ____________
4. Satisfaction with your partner ____________
5. Satisfaction with your sex life ____________
6. Satisfaction with your parenting ____________
7. Satisfaction with extended family

What are the 3 goals that you wish to accomplish from counseling?: ____________

How long do you expect to remain in counseling to achieve your goals?: ___________

Any additional information that is pertinent: ______________________________

*continue on reverse if needed

Client Signature:______________________________

Date:____________

Printed Name:______________________________