Biopsychosocial assessment form

Free template from soapnotes.xyz. Fill it in by hand or type over it.

BIOPSYCHOSOCIAL ASSESSMENT

Client

Date of assessment

Clinician

Referral source and reason

Sources of information

PRESENTING CONCERN

In the client's words, what brings them in:

When it started and what was happening then:

How it affects daily life (sleep, work or school, relationships, self-care):

What has been tried and what helped:

What the client hopes will change:

BIOLOGICAL

Current medical conditions and recent illness or injury:

Current medications and who prescribes them (list only):

Allergies:

Sleep, appetite and energy:

Alcohol, tobacco, cannabis and other substance use (type, amount, pattern):

Past hospital stays or surgeries:

Family history of mental health or medical conditions:

PSYCHOLOGICAL

Past mental health care (therapy, medication, hospital care) and how it went:

Current symptoms (mood, anxiety, thinking, perception, attention):

Past and current thoughts of self-harm, plans or attempts (asked, and the answer):

Thoughts of harming others (asked, and the answer):

Trauma or major adverse experiences (record only what the client chooses to share):

Coping skills and what the client does when stressed:

Mental status exam

SOCIAL

Living situation and who lives there:

Family and key relationships:

Friends and community support:

Education and employment:

Money, benefits and housing stability:

Legal matters:

Safety at home or in relationships:

Culture, language, faith or identity the client wants considered:

DEVELOPMENT AND HISTORY

Early development and childhood, as relevant:

Major life events and losses:

STRENGTHS AND SUPPORTS

Strengths, skills and interests:

Reasons for hope and protective factors:

Barriers to care (transport, cost, time, stigma):

RISK SUMMARY

Risk to self: [low / moderate / high], with the facts behind it:

Risk to others:

Vulnerability or safeguarding concerns:

Action taken:

FORMULATION

Biological factors:

Psychological factors:

Social factors:

What may have made the person more vulnerable (predisposing):

What set it off (precipitating):

What keeps it going (perpetuating):

What protects the person (protective):

IMPRESSION AND PLAN

Clinical impression (diagnosis if your role allows it):

Level of care recommended:

Goals the client has agreed to:

Referrals and follow-up, with dates:

Signature and credentials:

Educational template, not medical or legal advice. Follow your employer and regulator rules.