CLINTON COUNSELING CENTER – ADULT BIOPSYCHOSOCIAL ASSESSMENT

DEMOGRAPHICS

Legal Name:	Stephen Boerner	
Age: 38	Date of Birth: 06/26/1985	Social Security #: 159-68-7195
Race: x□ Caucasian □ Black □ Hispanic □ Native American □ Other:		
Current Address: Street: 2649 Tifton St. S City/State: Gulfport, Florida Zip: 33711		Current Phone: Home: 215-530-0545 Cell: 215-530-0545
Emergency Contact: Melissa Bemer		Phone: 610-613-5939
□ Guardian □ Representative payee X Personal representative Name: Melissa Bemer (wife)		Phone: 610-613-5939
Insurance Information: □ Medicaid □ Medicare □ Blue Cross/Blue Shield □ MiChild □ Value Options □ Cigna □ United Behavioral Healthcare X Aetna □ Adult Benefit Waiver □ Medicaid Spend down □ Other _____ □ No Insurance Benefits – current household income: _____		

SUBSTANCE USE HISTORY:

Consequences as a result of Drug/Alcohol Use (select all that apply)

□ Hangovers	□ Seizures	□ Sleep Problems	□ Drinking & Driving
□ Overdoses	□ Liver Disease	□ Lost Job	□ Stealing for drugs
□ Binges	□ GI Bleeding	□ Left School	□ Arrest
□ Blackouts	□ Increased tolerance (need more to get high)	□ Relationship Losses	□ Jail
□ DTs/Shakes		□ Traded sex for drugs	□ Other:

Risk Taking/Impulsive Behaviors (current or past) – select all that apply

□ Gambling	□ Gang involvement	□ Selling drugs	□ Reckless driving
□ Unprotected sex	□ Shoplifting	□ Carry/using weapons	□ Other _____

Client's thoughts about making changes to substance use:

□ Not ready to quit	□ Making plans to quit	□ Quit and need help to prevent a relapse
□ Thinking about quitting	□ Already started making changes	

History of Substance Abuse Treatment: □ No previous treatment

Name of Treatment Program	Type of Treatment	Date of Treatment	Status
Does Not Apply - No History of Substance Abuse, nor Treatment	□ Inpatient □ IOP □ Outpatient	Does Not Apply - No History of Substance	□ Completed □ Dropped Out □ Other:
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Inpatient □ IOP □ Outpatient		□ Completed □ Dropped Out □ Other:

Clinical Impression: (Staff use only):

PSYCHOLOGICAL/EMOTIONAL:

Check all current symptoms:

□ Depressed mood	□ No motivation	□ Sleep problems	□ Hallucinations
□ Frequent crying spells	□ No interest in activities	□ Manic episode	□ Paranoia
□ No energy	□ Changes in weight	□ Panic attacks	□ Thoughts of death
□ Irritable often	□ Feeling worthless	□ Constant worry	□ Obsessions
X □ Problems concentrating	□ Hopelessness	X □ Anxiety	□ Hyperactivity

History of Suicide Attempts X □ No □ Yes When:_____ How: _____

History of Hurting Others X □ No □ Yes When: _____ How: _____

Past/Current Mental Health Diagnosis: General Anxiety

Current Mental Health Medications: Amphetamine-dextroamphetamine 10 MG x2/day

Doctor prescribing medications? Name: Peter D'Orsaneo, CRNP Phone: 215-829-3523

Address: 1840 South St. 1st Floor, Philadelphia, PA

Past Mental Health Medications: Only Mental Health Medication on Record: Amphetamine-

Family history of mental health disorders:

Family Member	Diagnosis
No history of mental health	No history of mental health diagnosis

History of Mental Health Treatment: X No previous treatment

Name of Treatment Program	Type of Treatment	Date of Treatment	Status
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:
	□ Hospital □ Partial Day □ Outpatient		□ Completed □ Dropped Out □ Other:

Clinical Impression: (Staff use only):

MEDICAL:

Medical Condition(s):	Medication(s)	Dose
Mild Hyper-tension	Olmesartan-amLODIPine-HCTZ	40-5-25 MG

Allergic to any medications? □ No ☒ Yes What medication(s)? Augmentin

Primary Care Physician's Name:	Address:	Phone:
Peter D'Orsaneo, CRNP □ No primary care physician	1840 South St. 1st Floor Philadelphia, PA 19146-7411	215-829-3523

Detoxification History: Substance(s): _____ ☒ Never detoxed

Symptoms: □ DTs/Shakes □ Vomiting □ Diarrhea □ Seizures □ Achy □ Sleeplessness
□ No appetite □ Anxiety □ Hallucinations □ Other: _____

Current Sleep: ☒ No sleep problems □ Can't fall asleep □ Waking often in the night
□ Sleep more than 9 hours per night □ Sleep less than 6 hours per night

Current Exercise: □ None ☒ Exercise 1-3x/month □ Exercise 1-3x/week □ Exercise daily

Current Diet: ☒ Healthy eating □ Overeating □ Eating mostly junk food
□ Bulimia (eating too much and vomiting) □ Anorexia (not eating enough)

Current appetite: ☒ Good □ Fair □ Poor

Clinical Impressions: (Staff use only):

FAMILY OF ORIGIN: (What happened while growing up – check all that apply)

Who raised client? ☒ Mother ☒ Father □ Grandparent □ Other: _____

Substance use in the family? ☒ No □ Yes Who? _____

Client was disciplined by: □ Not disciplined □ Spanked/hit □ Yelled at ☒ Time out/grounding

Verbal Abuse? ☒ No □ Yes Age of abuse _____ By Whom? _____

Physical Abuse? ☒ No □ Yes Age of abuse _____ By Whom? _____

Neglect? ☒ No □ Yes Age of abuse _____ By Whom? _____

Impression of upbringing: ☒ Healthy □ Fair □ Dysfunctional

Clinical Impressions: (Staff use only):

ETHINIC/CULTURAL/SPIRITUAL BACKGROUND:

What cultural group do you identify with the most (check all that apply):

☒ Caucasian (White)	□ African American (Black)	□ Latino
□ Asian	□ Hispanic	□ Native American
□ Other: _____		

What religious group do you identify with the most (check all that apply):

☒ None	□ Baptist	□ Lutheran	□ Protestant	□ Jewish
□ Catholic	□ Muslim	□ Non-denominational	□ Jehovah Witness	□ Other: _____

What are your spiritual beliefs?

☒ Believe in Higher Power	☒ Uses prayer	☒ Seeking connection with others
☒ Seeking harmony	☒ Believe in Karma	☒ Want to strengthen spirituality

Clinical Impressions: (Staff use only):

SEXUALITY:

Check all that apply:

Sexual Orientation:	☒ Heterosexual (like opposite sex) □ Homosexual/Gay/Lesbian □ Bisexual (like both sexes) □ Transgender □ Comfortable with sexual orientation □ Concerns with sexual orientation
Sexual abuse:	□ Have been sexually abused Age of abuse:_____ By whom: _____ □ Have sexually abused others ☒ No history of sexual abuse □ Sexual abuse history is a current area of concern

Clinical Impressions: (Staff use only):

CURRENT FAMILY RELATIONSHIPS:

Marital Status: □ Never Married ☒ Married □ Separated □ Divorced □ Widowed

□ Living with partner □ In relationship

Children: ☒ None

Name	Age	Gender	Client has custody?	Child lives with?	Additional information
		□ M □ F	□ Yes □ No		
		□ M □ F	□ Yes □ No		
		□ M □ F	□ Yes □ No		
		□ M □ F	□ Yes □ No		

Has client ever had involvement with Child Protective Services? ☒ No □ Yes Year: _____

Check all that apply:

	Deceased	Regular contact	Infrequent/ No contact	Supports recovery	Does not understand recovery	Used substances with	Conflict in relationship
Spouse/Partner	*						
Mother							
Father							
Sibling: _____							
Sibling: _____							
Sibling: _____							
Child: _____							
Child:_____							

* Does not apply. Stephen Boerner is not in recovery nor has any history of substance

Identify family that would be willing to participate in treatment to assist client in recovery: _____

Clinical Impression: (Staff use only):

CURRENT SOCIAL SUPPORTS:

Check all that apply:

□ No current social support	□ Isolating	□ Have a current sponsor
□ Friends that use substances	□ Anxiety makes it hard to meet people	X Friends that support recovery

AA/NA Meetings (check all that apply):

X Never attended any meetings	□ Don't like meetings	□ Attend meetings 1-3x/month
□ Attended meeting in the past	□ Find meetings helpful	□ Attend meetings 1-3x/week
□ Currently attending meetings	□ Need to go to meetings again	□ Attend meetings daily

Clinical Impression: (Staff use only):

CURRENT LEISURE/RECREATION/TIME MANAGEMENT:

Check all that apply: □ Do not participate in any activities

Activity	Past activity	Present activity	Substance use involved with this activity
Time with friends	Yes	Yes	None
Time with family	Yes	Yes	None
Classes/School	n/a	n/a	n/a
Work	Yes	Yes	None
Hobby: Golf, Computers	Yes	Yes	None
Watch television/Play video games	No	No	No
Clubs/Bars	No	No	No
Casinos	No	No	No
Participate in sports/exercise	Yes	Yes	None
Other: None			

Clinical Impression: (Staff use only):

EDUCATIONAL:

Check all that apply:

Education: X High School Graduate or GED □ Less than 12 years of school: Last grade completed: _____ X College: # of years 6 □ Vocational Schooling: # of years Masters Degree
Current Schooling: X No □ Yes
Do you need help with reading and/or writing? X No □ Yes
Any learning disabilities or other educational or learning problems? X No □ Yes: _____
How do you learn the best? □ Reading □ Writing □ Listening to information X Practicing

Clinical Impression: (Staff use only):

EMPLOYMENT/VOCATIONAL:

□ EMPLOYED □ Full-time □ Part-time X Contractual/Side Jobs
Employer: Self-employed by North New Associates, Inc. Length of Employment: 4 Months
Job Description: Oversees a diverse portfolio of digital assets
Check all that apply: X Satisfied □ Not satisfied □ Conflict with supervisor □ Conflict with coworkers
□ I have used substances at work □ Others use substances at work
□ Employment will help with recovery □ Employment could hurt recovery
Explanation: _____

□ UNEMPLOYED Last employer: _____
Reason for leaving: _____
□ Currently looking for work □ Disabled □ Need job skills training □ Currently in school
□ Never been employed □ Homemaker □ Unstable work history □ History of Military service
□ Not looking for work due to: _____

Clinical Impression: (Staff use only):

LEGAL:

Current Legal Status: □ None □ Probation □ Parole □ Awaiting Sentencing □ Awaiting Trial

History of Legal Charges:

Charge (most recent first)	Year Arrested for Charge	Outcome
None - Does not apple		

Clinical Impression: (Staff use only):

FINANCIAL STATUS:

Check all that apply:

Finances are: X Stable □ Struggling to pay bills □ Need assistance with basic needs

Need help with: X Nothing □ Rent/Mortgage □ Food □ Utilities (electric, gas, water)
□ Healthcare □ Transportation □ Other: _____

Money management: X Able to budget □ Gambling problems □ Compulsive spending □ Hoarding money

Clinical Impression: (Staff use only):

FUNCTIONAL ASSESSMENT:

Client able to care for self? X Yes □ No – Explain:
Living Situation: X Housing adequate □ Housing overcrowded □ Housing dangerous □ Doubled up – living in someone else's house □ Transitional or ¾ housing □ Homeless □ Temporary Shelter □ At risk of homelessness
Assistive/Adaptive Needs: □ Glasses/Contacts □ Braille □ Cane X None □ Hearing Aids □ Reads lips □ Needs sign language □ Walker □ Crutches □ Wheelchair □ Translated verbal information – Language: _____ □ Translated written information – Language: _____

SNAP (Strengths, Needs, Abilities and Preferences)

Strengths: X Family support □ Desire for help □ Social support □ Financial stability □ Spiritual X Resilient □ Stable relationship □ Stable housing □ Other: _____
Needs: □ Coping skills □ Relapse prevention skills □ Support for recovery X Medications □ Transportation □ Financial help □ Other: _____
Abilities: X Insightful X Good communication skills X Good writing skills □ Other: _____
Preferences: □ Appointment times – Needs: _____ □ Therapist in Recovery X Male Therapist □ Female Therapist □ Group therapy □ Individual therapy