CGST COUNSELLING CENTRE
CARIBBEAN GRADUATE SCHOOL OF THEOLOGY
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ADULT BIOPSYCHOSOCIAL ASSESSMENT

*THIS FORM IS CONFIDENTIAL

CLIENT'S GENERAL INFORMATION

Client's Name: _____ Birth Date: ____ /____ /____

Age: _____ Gender: Male / Female

Presenting Problem(s)

State in your own words the nature of the problem you are seeking help for: _____
_____

When did the problem begin? _____

What do you hope to accomplish through the counseling process? _____
_____

Please tick the behaviours and symptoms currently affecting you and state duration:

Behaviour/Symptoms		Duration	Behaviour/ Symptoms		Duration	Behaviour/ Symptoms		Duration
Anxiety/ Nervousness			Suspicion/Paranoia			Sleeping Problems		
Irritability/ Anger			Obsessive Thoughts			Eating Problems		
Aggression			Compulsive Behavior			Recurring Nightmares		
Sadness/Depression			Impulsivity/Hyperactivity			Weight Loss/Gain		
Mood swings			Memory/Concentration			Sexual problems		
Stress			Panic Attacks			Pornography		
Low self Esteem			Racing Thoughts			Menopause/ Menstrual Problems		
Hopelessness			Recurring/Disturbing Memories			Computer Addiction		
Loneliness			Flashbacks Fear/Phobias			Alcohol/Drug Use		
Social Discomfort			Hallucinations			Gambling		
Loss of Pleasure/ Interest			Self-Harm behaviors			Finances		
Withdrawal			Suicidal Thoughts			Work/School Problems		
Guilt/Shame			Homicidal Thoughts			Parenting Problems		
Fatigue			Bereavement/ Feeling of Loss			Marital/ Relationship Problems		

Counsellor's/Therapist's Notes for presenting concern:

HEALTH AND MEDICAL INFORMATION

PHYSICAL HEALTH

Current Physician's Name: _____

Address: _____ Tel #: _____

Current Medical Problem: _____

Current Medication(s): _____

Date of last physical/medical exam: _____

Any surgery or hospitalization (dates & reasons) _____

MENTAL HEALTH

Have you / Are you currently receiving psychiatric or counselling service ☐ Yes ☐ No

If yes, whom did you see and when? _____

What was the nature of the difficulty you were experiencing? _____

Was previous counseling helpful? (Explain) _____

_____

Have you been prescribed or are currently taking psychiatric medication? ☐ Yes ☐ No

If yes, list (current): _____ (Past) _____

Any history of psychiatric hospitalizations (dates & reasons) _____

_____

Any history of traumatic experiences (Explain)? _____

_____

Counsellor/Therapist's notes for Health and Medical History:

Family and Developmental History

Do you live alone? ☐ Yes ☐ No If no, who lives with you? _____

Current Relationship Status: Single ☐ Married ☐ Separated ☐ Divorced ☐
Widowed ☐ Co-habiting ☐

Length of Marriage/Cohabitating _____

Number of Children (including stepchildren) & Ages: _____

_____

Describe your relationship with your spouse/partner _____

Are there any problems currently affecting your relationship with your spouse/partner?

☐ Yes ☐ No If yes, explain _____

Describe your relationship with your children _____

Who raised you? _____

Are your parents: ☐ Married ☐ Co-habiting ☐ Separated ☐ Divorced

Number of Siblings & Ages: Sisters _____ Brothers _____

Describe your relationship with your parents, past and present _____

Describe your relationship with your siblings, past and present _____

Did your mother suffer any complications during pregnancy/childbirth with you? ☐ Yes ☐ No

If yes, explain _____

Did you experience any developmental delays or problems as a child (walking, talking, toileting etc)

☐ Yes ☐ No If yes, explain _____

Did you suffer any major childhood illnesses/ injuries or had major surgery? ☐ Yes ☐ No

If yes, explain _____

Is there any history of mental or physical illness in your family? ☐ Yes ☐ No

If yes, explain _____

Counsellor's/Therapist's notes for Family and Developmentally History:

Substance Use History

Drug	Have you ever used? Y	N	Currently Using? Y	N	Age of 1st Use	Frequency	Amount	Last Use
Alcohol								
Caffeine								
Nicotine (Cigarettes, Tobacco)								
Marijuana (Ganja)								
Cocaine/ Crack								
Opioids (Heroin)								
Sedatives/ Hypnotics								
Hallucinogens (LSD, PCP, Ecstasy)								
Stimulants (Amphetamine, Speed)								
Inhalants (Glue, Gasoline, Paint)								
Other (Pain Killers Steroids, GHB etc.)								
Tranquilizers								

Have you had withdrawal symptoms when trying to stop using any substances?

☐ Yes ☐ No If yes, describe: _____

Have you ever had problems with work, relationships, health, the law due to your substance use? ☐ Yes ☐ No

If yes, describe: _____

Counsellor's/Therapist's notes for Substance Abuse History:

Miscellaneous Information - Recreation & Leisure

What are your personal hobbies and/or interests? _____
_____

How often do you involve yourself in your hobbies/interests? _____
_____

How often do you exercise? _____What type of exercise and for how long? _____

Please describe your social support network (check all that applies):

☐ Family ☐ Neighbours ☐ Friends ☐ Peers

☐ Support/ Self-Help Groups ☐ Community Group ☐ Religious Groups

What do you consider to be your strengths? _____

Education

Highest Grade completed? _____
Degree(s) completed? _____
Did you have academic, behavioural, or social difficulties in school? ☐ Yes ☐ No
If yes, explain: _____

Employment

Employer: _____
Position: _____
Length of time in this position: _____
Stress level of this position:
☐ Low ☐ Medium ☐ High

Military Service

Have you been/are you currently in the military? ☐ Yes ☐ No
(If no, skip remainder of this section)
Branch _____ Rank _____
Date of Discharge? _____
Type of Discharge? _____
Were you in combat? ☐ Yes ☐ No
How Long? _____

Legal History

Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No
If yes, explain_____
Are you currently involved in any divorce or child custody proceedings? ☐ Yes ☐ No
If yes, explain_____

Counsellor's/Therapist's Notes for Miscellaneous Information: