TWT
The Way Through

Bio-psycho-social Assessment

Please fill out this form and bring it to your first session. Information you provide is protected as confidential.

Name:

_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □Divorced □ Widowed

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Phone: (____) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

Referred by/or how did you find us? _____

Please mark your situation or loss by checking the appropriate box:

Death □
Name of deceased _____Age_____ Date_____

Relationship_____ Cause of death _____

Divorce or Separation □
Date of divorce or separation_____ Explain _____

Life Situation □
Type of life situation_____

Alcohol or Drug Recovery □
Type of addiction _____Recovery date (if any) _____

Current Reactions	None	Slight	Moderate	Acute
Anger	□	□	□	□
Sadness	□	□	□	□
Guilt	□	□	□	□
Anxiety	□	□	□	□
Sleeping issues	□	□	□	□
Eating issues	□	□	□	□

Please add any addition reactions:

_____

_____

Have you previously or are you currently receiving any type of mental health services?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes □ No if so, please summarize:

_____

_____

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

Do you drink alcohol or use drugs to cope? □ No □ Yes Which type?_____

How often? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Available Support	Excellent	Fair	Poor	None
Family	□	□	□	□
Friends/neighbors	□	□	□	□
Spiritual Support	□	□	□	□
Co-Workers	□	□	□	□

Other (identify) _____

Complications:

Unexpected situation	Yes □	No □
Involves a child	Yes □	No □
Violence or trauma	Yes □	No □
Do you think about suicide?	Yes □	No □
Prolonged situation?	Yes □	No □
Past unresolved Issues	Yes □	No □
Financial difficulties	Yes □	No □
Job/work stress	Yes □	No □

What seems to be the biggest challenge for you today?

_____

_____

_____

Anything else you want us to know?

_____

_____

Please circle the services you may be interested in:

Crisis Intervention Grief Counseling Couples Counseling

Individual Counseling Family Therapy

Child Counseling EMDR Treatment PTSD Treatment

Addiction Recovery Alcoholic Recovery Support Groups

Psychotherapy Telephone/Online Therapy Home

Visits Community Referrals Book Referrals