Neurobiopsychosocial History

Name: DOB:

Date: Information provided by:

A. Reason for seeking services:

Referred by:

Concerns, from the referral source's perspective:

Concerns, from your perspective (if different):

Concerns, from the perspective of others:

B. Family history:

Your parents' relationship with each other:

Your relationship with each parent growing up (list three adjectives that describe the nature of the relationship):

Your relationship with each parent, as of today (list three adjectives that describe the nature of the relationship):

Your parents' problems with physical health, substance use, or mental health:

I am the ☐ oldest child ☐ middle child ☐ youngest child ☐ only child

Your relationship with your siblings (list three adjectives that describe the nature of the relationship):

Other important family members to you:

C. Cultural background: I belong/self-identify with the following cultural groups:

_____ race/ethnicity _____ gender

_____ sexual orientation _____religion

_____ (include any others here)

D. Symptoms:

During the past two weeks, mark an "X" in the appropriate column for how much (or how often) you been bothered by the following problems.

Problem	**None** (not at all)	**Slight** (rare, a day or two)	**Mild** (several days)	**Moderate** (more than half the days)	**Severe** (nearly every day)
Little interest or pleasure in doing things?					
Feeling down, depressed, or hopeless?					
Feeling more irritated, grouchy, or angry than usual?					
Sleeping less than usual, but still have a lot of energy?					
Starting lots more projects than usual or doing more risky things than usual?					
Feeling nervous, anxious, frightened, worried, or on edge?					
Feeling panic or being frightened?					
Avoiding situations that make you anxious?					
Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?					
Feeling that your illnesses are not being taken seriously enough?					
Thoughts of actually hurting yourself?					
Hearing things other people couldn't hear, such as voices even when no one was around?					
Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?					
Problems with sleep that affected your sleep quality over all?					
Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?					
Unpleasant thoughts, urges, or images that repeatedly enter your mind?					
Feeling driven to perform certain behaviors or					

mental acts over and over again?					
Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?					
Not knowing who you really are or what you want out of life?					
Not feeling close to other people or enjoying your relationships with them?					
Drinking at least 4 drinks of any kind of alcohol in a single day?					
Using any of the following medicines without a doctor's prescription, in greater amounts or longer than prescribed: painkillers (like Vicodin), stimulants (like Adderall), sedatives (like Ambien or Valium)?					
Using drugs like marijuana, cocaine or crack, club drugs like ecstasy, hallucinogens like LSD, heroin, inhalants or solvents like glue, or methamphetamine (speed)?					

Table taken from DSM-5 Level 1 Cross-Cutting Symptom Measure.

Eating patterns (e.g., detail typical eating frequency, amount, self-reported eating too much, not enough, feeling out of control while eating, feeling guilt after eating, etc.):

Physical activity (e.g., amount and type of physical movement in an average day):

E. Coping strategies:

How do you usually cope with these symptoms?

Which people in your life support you?

F. History of medical conditions and treatment:

Provider	Date	Diagnosis	Treatment	Results

G. History of mental health treatment (counseling and/or medication):

Provider	Date	Diagnosis	Treatment	Results

H. Developmental history:

☐ Prenatal issues
☐ Developmental delays
☐ Parental divorce
☐ Grief/loss _____

Any other notable details about developmental history:

Experiences of abuse:

Your age at the time	Kind of abuse*	Approximate dates when abuse occurred	By whom?	Whom did you tell?	Effect of telling?

* i.e., physical abuse, sexual abuse, psychological abuse, neglect

Neurological Dysregulation Risk Assessment

Name:_____ Age: _____ Date:_____

Current Problem, Symptom, or Complaint: _____

Please read each potential source of neurological dysregulation and indicate whether or not it may be a risk factor for you or your child.

❑ Yes ❑ No	**Genetic Influences:** Grandparents, parents, or siblings with mental health or learning disorders (including attention-deficit/hyperactivity disorder), posttraumatic stress disorder, depression, generalized anxiety disorder, substance abuse, personality or other severe psychological disorders (bipolar or schizophrenia).
❑ Yes ❑ No	**Prenatal Exposure:** Maternal distress, psychotropic medication use, alcohol or substance abuse, nicotine use, or possible exposure to environmental toxins including genetically modified foods, pesticides, petrochemicals, xenestrogens in plastics, heavy metals (lead/mercury), and fluoride, bromine, and chlorine in water.
❑ Yes ❑ No	**Birth Complications:** Forceps or vacuum delivery, oxygen loss, head injury, premature birth, difficult or prolonged labor, obstructed umbilical cord, or fetal distress.
❑ Yes ❑ No	**Disease and High Fever:** Sustained fever above 104 degrees due to bacterial infection, influenza, strep, meningitis, encephalitis, Reye's Syndrome, PANDAS, or other infections or disease processes.
❑ Yes ❑ No	**Current Diagnosis:** Of mental health, physical health, alcohol abuse, or learning disorder.
❑ Yes ❑ No	**Poor Diet and Inadequate Exercise:** Diet high in processed food; preservatives; simple carbohydrates (sugar and flour); genetically modified foods; foods treated with herbicides; pesticides, and hormones; low daily water intake, high caffeine intake; and lack of adequate physical exercise (20 minutes, 7 times a week).
❑ Yes ❑ No	**Emotionally Suppressive Psychosocial Environment:** Being raised or currently living in poverty; domestic violence; physical, emotional, or sexual abuse; alcoholic or mentally unstable family environment; emotional trauma; neglect; institutionalization; and inadequate maternal emotional availability or attachment.
❑ Yes ❑ No	**Mild to Severe Brain Injury:** Experienced one or more blows to the head from a sports injury, fall, or auto accident (with or without loss of consciousness), or episodes of open head injury, coma, or stroke.
❑ Yes ❑ No	**Prolonged Life Distress:** Most commonly due to worry about money, work, economy, family responsibilities, relationships, personal safety, and/or health causing sustained periods of anxiety, irritability, anger, fatigue, lack of interest, low motivation or energy, nervousness, and/or physical aches and pains.
❑ Yes ❑ No	**Stress-Related Disease:** Includes heart disease, kidney disease, hypertension, obesity, diabetes, stroke, hormonal, and/or immunological disorders.
❑ Yes ❑ No	**Prolonged Medication Use, Substance Use, or Other Addictions:** Including legal or illegal drug use, substance abuse, or addiction (alcohol, drugs, nicotine, caffeine, medication, gambling, sex, spending, etc.) and overuse of screen technologies (cell phones, video games, television, computers, Internet, etc.).
❑ Yes ❑ No	**Seizure Disorders:** Caused by birth complications, stroke, head trauma, infection, high fever, oxygen deprivation, and/or genetic disorders and includes epilepsy, pseudoseizures, or epileptiform seizures.
❑ Yes ❑ No	**Chronic Pain:** Related to accidents, injury, or a disease process. Including back pain, headache and migraine pain, neck pain, facial pain, and fibromyalgia.

I. Current living situation:

Current partner: Length of relationship:

People living in the home:

Relationship	Name	Age	Occupation	Any problems?

☐Own home ☐Rent house ☐Rent apartment ☐Financial Stressors

Moves:

Location	Year	Reason for move

J. Occupational/Educational History:

Top 3 occupational/educational problems or issues:

1.

2.

3.

If still in K-12 grades:

☐ repeated a grade ☐ suspended ☐ expelled ☐ moved schools

☐ advanced/gifted classes ☐ special education/disability services ☐ IEP ☐ 504 plan

If completed K-12 schooling: highest education level completed

High School: ☐ currently attending ☐ dropped out ☐ completed/graduated ☐ GED
Undergraduate: ☐ currently attending ☐ dropped out ☐ completed/graduated

Degree:_____ College: _____

Graduate: ☐ currently attending ☐ dropped out ☐ completed/graduated

Degree:_____ College: _____

What are your occupational or educational goals?

[If adolescent] Post-high school goals:

[If adult] Career goals:

Work history:

Position	Company	Dates	Reason for leaving

K. Legal history:

Current/pending legal charges:

Past legal charges:

Convictions: ☐ misdemeanor ☐ felony

Incarceration record:

Conviction	Year	Length of sentence