huron gastro

BIOPSYCHOSOCIAL ASSESSMENT

Please answer all questions. Thank you.

Person completing this form: Birthdate:

Patient's Name:

Today's Date:

Your treatment goals are of the highest importance to us. Please complete the following questions: your therapist will discuss these with you on your first visit.

Why are you seeking GI Behavioral Health therapy now?

What would you like to be different for you after Behavioral Health treatment here?

Strengths & Abilities: (examples: good support system, motivation, coping skills, talents, etc.) and skills, capabilities, competencies, and talent.

Needs: Specific things that will make treatment here successful) e.g., figuring out consistent transportation, prioritizing therapy, accessibility of services re: disability, need for assistive technology, support of family, etc.)

Preferences: In person at Huron Gastro and or Telehealth Zoom Visits.

Barriers: Is there anything that may get in the way of you achieving your goals for therapy?

What are your goals for GI Therapy?

What has already been done or tried to address your goals that you have for GI Behavioral therapy? (Examples, diet, medications, etc.)

Gastrointestinal behavioral health

What challenges, if any, are you currently having with your digestive issues?

What is the length of time you have been dealing with your GI condition?

What are you currently doing to manage your GI condition and symptoms?
(Examples, diet, medications, etc.)

Are you satisfied with the past treatments to treat your GI condition? If yes, please share. If not, please share.

Please answer the questions below with Never, Sometimes, Often, always.
Never, sometimes (several times a month) Often (Several times a week) Always (Daily).

How often do you think about your GI condition?
Do you avoid attending events if you do not have a bathroom nearby?
How often, if any, do you have urgency to use the bathroom when going out in public?
How often, if any, do you have an urgency to use the bathroom when at home?
How often, if any, have you had a bathroom accident when going out in public?
How often does your stomach hurt and or ache?
How often does your GI condition impact your day-to-day life?
Do you share with those closest to the impact of your GI condition?

Stress Management Questions

Do you have trouble staying focused on the present moment?
How often do you feel overwhelmed with your life?
Do you struggle to fall asleep at night?
On average, do you get less than 7-8 hours of sleep a night?
Do you turn to unhealthy food indulgences such as eating junk food, drinking excessively, or eating sugary foods when feeling overwhelmed?
Do you experience headaches or muscle tension?
During work hours, do you have a tough time staying focused and concentrating on the task-at-hand?
Do you feel pain or tension in your stomach, muscles, chest, or head?

Psychological Symptoms and History
Please circle any of the following that currently apply for you

Feeling tense	Trouble concentrating	Fatigue/feeling tired	Weight changes
Feeling fearful	Easily distracted	Nightmares	Purging Food
Panic attacks	Memory problems	Appetite change	Food restriction
Easily startle	Procrastination	Self-injury/cutting	Hair-pulling
Trauma/abuse	Careless mistakes	Excessive spending	Skin-picking
Being scared for no reason	Starts but does not finish tasks	Impulsivity Hyperactivity	Upset stomach
Worrying what others think	Irritability/easily annoyed	Seeing/hearing things that other people do not see/hear	Headaches
Having to redo things or check things	Sadness easily Crying	Feeling something is wrong with your mind	Anger
Doing things very slowly to make sure they are correct	Hopelessness	Feeling disoriented or confused	Defiance
Unwanted thoughts	Worthlessness	Feeling high without being on drugs	Bedwetting
Avoids situations people/things due to fear	Low self-confidence	Mood swings	Toileting issues
Asking others for reassurance	Feeling inferior	Feeling numb	Sexualized behaviors
Family problems with parents/guardians	Low energy level	Feelings being easily hurt	Excessive Anger
Difficulty making friends	Difficulty making decisions	Intrusive thoughts	
Withdrawing	Feeling confused	Difficulty controlling actions	
Loneliness	Loss of interest/pleasure	Being suspicious of others	
	Thoughts of suicide		
	Increased sleep		
	Decreased sleep		
	Problems falling asleep		

Previous Counseling/Psychotherapy

Have you been seen previously for GI Behavioral Therapy? Yes or No

Have you been seen previously for treatment/therapy/Counseling. Yes or No

Check if applicable:

Inpatient__ Residential__ Day Treatment/Partial Hospitalization__ Substance Abuse Program__

Outpatient__ Psychological Testing__ Psychiatric Evaluation __

Name of Facility and/or Provider Date(s) Problem Area/Diagnosis & Type of Therapy Was it helpful?

Have you had (now or in the past):

Check if applicable:

Had suicidal feelings or thoughts__ suicide plan suicide attempt(s)__ self-harm behavior (cutting, etc.) __ explosive anger__ homicidal feelings, thoughts, or plan __

no history of suicidal/homicidal thoughts plans, or actions, now or in the past__

Comments:

Substance Use Information

Did you use any of the following substances, check any that apply.

Alcohol__ Drugs__ Coffee/Caffeine__ Tranquilizers/sleeping pills__ Anti-seizure medication__ Insulin or other diabetes treatment__ Other prescribed medications__ Marijuana __ None of these___

If substances were checked above, please describe amount used and frequency (how often)

Milestones

Did biological mother experience any health problems or illness during pregnancy? Yes No

Were there any pregnancy or delivery complications? Yes No

Were specialized medical attention or tests required at birth? Yes No

Comments:

Check any of the following medical conditions that you have had or currently have.

Major accident/injury	Blood pressure (high/low)	Hearing problem	Speech/language problem
Hospitalization	GI problems	Heart disease	Stroke
Surgery	Cancer	Hepatitis A, B or C	Thyroid (Hypo/Hyper)
Adverse medication reaction	Cerebral Palsy	Hypoglycemia	Ulcer
Allergies	Chronic fatigue	Huntington's	Vision problem
Anemia	Dental problems	Kidney problems	Other (please list)
Angina	Diabetes	Learning Disability	
Arthritis	Epilepsy	Liver problems	
Asthma	Fibromyalgia	Lung condition	
Birth defects	Head trauma (loss of consciousness	Menopause	
Bladder problems	Headaches	Multiple Sclerosis	
		Parkinson's Disease	

Please provide additional detail about items checked above:

Do you have any disabilities not noted thus far? Yes or No If yes, please describe:

Do you use any assistive devices/technology? Yes No If yes, please describe

Please list any psychiatric medications you are currently taking and or have used in the past:

If not applicable, please check here ___

Identifiers: Please check information that applies.

Ethnic identification

African American___ Caucasian___ Native American___ Hispanic___ Latino___ Asian___

Sexual Identification
Straight___ Gay/Lesbian___ Bisexual___ Other___

Gender Identity & Expression:

Family Information
Place of birth:
Adoption? If yes, age at adoption: ____
Foster family Orphanage

Relationship Status: Married/Partnered/Cohabitating___ Separated___ Divorced Other___
Comments:

Please list people currently living with you in your primary residence

Name	Relationship	Age	Occupation

Comments:

Social Support
Do you have sufficient social support? Yes or No
If not, please explain.

Describe relationships with family members (significant other, parents, siblings, etc.)

Family Mental Health
Do you have any immediate family members who have had mental health problems (anxiety, depression, substance use, suicide, etc.)? If yes, please describe.

Educational Information

Did you graduate from High School? Yes or No

If not, what is the highest grade level completed?

Did you attend College? Yes or No

If yes, how many years?

Degree completed.

Do you have any additional training and significant work you would like to share?

Employment History

Are you currently employed? Yes or No

If yes, where are you employed?

Are you satisfied with your job? Yes or No

What would you do if you could live out your dream job and or passion?

Additional Comments you may like to share.

Religion/Spirituality

Are you presently active in religion and or spirituality? Yes or No

If yes, please feel free to share below what that is for you.

Substance Use: Please complete the chart below and circle any of the substances listed if used in the past month. N (No), Y (Yes).

Category of substance	Current use	Ever used	Amount and frequency (e.g., 8 beers a day)	Use has led to social, health, legal or work problems'	Unable to do what is expected of me, due to use	Others express concern over use	Have urges to use, but not using	Have urges to cut down and or stop	Withdrawal symptoms
Alcohol	N or Y								
Stimulant	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Cocaine	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y

Tranquilizer	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Barbiturate	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Marijuana	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Opioid	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Hallucinogen	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Prescribed	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Nicotine	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Caffeine	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y
Other	N or Y	N or Y		N or Y	N or Y	N or Y	N or Y	N or Y	N or Y

Legal Information
(currently and/or past): **If any, legal difficulties, please describe:**

Had difficulty with the police: Yes or No
Appeared in juvenile conference: Yes or No
Been convicted of a crime: Yes or No
Patient Name:
Been on probation? Yes or No
No History of legal problems.

Leisure Activities
Please list activities and preferences for what you like to do in your free time.

Comments (e.g., enjoyment, satisfaction, etc.)