



005 PATIENT HEALTH PROFILE

St. Vincent Health

PATIENT HISTORY

Adult Biopsychosocial Form

Patient ID _____

INSTRUCTIONS TO PATIENT/FAMILY: Please complete this portion of the form. It will provide us with important information about you and your needs.

Patient Name _____ Date _____

Current Living Situation – Please complete

FAMILY MEMBER / SIGNIFICANT OTHER / OTHER	AGE	RELATIONSHIP TO PATIENT	LIVING WITH PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	OCCUPATION
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

FAMILY/OTHER IMPORTANT RELATIONSHIPS: Please note marital status, past marriages, divorces, dating, and other important relationships. Describe degree of support received from family, friends, school, support groups, and others.

FAMILY OF ORIGIN: Please describe your relationships with parents/caregivers and brothers/sisters. Note any family problems that were present, such as a history of drug abuse or mental illness in family members.



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EDUCATION: Provide level of schooling completed, feelings about school, and grades. Please note any discipline problems or learning difficulties. Also, please indicate how you prefer to learn (for example: reading, practicing, talking, or watching).

EMPLOYMENT: Provide work history, retirement, terminations, problems on the job, EAP involvement, relationships with co-workers and bosses, shifts, and hours worked per week.

Not applicable

MILITARY SERVICE: Yes No

If Yes: Active Duty Retired Reserves Discharged Other _____

Type of Discharge: Honorable General Less than Honorable

LEGAL HISTORY: Note any legal difficulties including arrests, probation, nature of charges, convictions, pending charges, guardianship, Power-of-attorney.

Not applicable

RELIGION/SPIRITUALITY: Please describe past and present religious affiliations, involvement in faith community, and guiding spiritual principles.

Are there any spiritual/religious issues you would like help addressing? No Yes, describe:

What spiritual/religious resources do you make use of? (Check all that apply)

Prayer Faith Community Spiritual Friend Spiritual Reading Church Attendance
 Other _____



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CULTURAL: Please describe your ethnic background, community, and customs. Include any cultural issues you would like help addressing.

Please list any cultural issues/practices you would like us to be aware of that would affect your treatment.

None reported

VIOLENCE/ABUSE: Please describe any physical, verbal, emotional or sexual abuse as the perpetrator, victim, or witness. Was the abuse reported to the authorities?

Not applicable

FINANCIAL STATUS: Please describe current financial situation. Please include past and present credit history and if you are receiving disability or public assistance.

- Financially secure Finances are a source of stress Currently in debt
- Plan to file bankruptcy Filed bankruptcy – Year(s) _____ Social Security disability

NUTRITIONAL STATUS: Please describe how many meals you eat per day, and special diet, snacks or food allergies.

Please note any problems you have with the following:

- Weight loss in the last 3 months Yes No How much? _____
- Weight gain in the last 3 months Yes No How much? _____
- Binge-eating Yes No How much? _____
- Purging Yes No How much? _____
- Diuretic Abuse (water pills) Yes No
- Laxative Abuse Yes No
- Glasses of water or fluid a day _____

ACTIVITIES OF DAILY LIVING (Grooming, hygiene, daily routine):

- Independent (I require no assistance from others)
- Minimal Assistance (I require verbal or physical cues/prompts by others)
- Partial Assistance (I require assistance to initiate or complete one or more steps of the process)
- Maximum Assistance (I require assistance at all times to initiate and complete all steps of the process)
- Youth – ability is age specific



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LEISURE ACTIVITIES / DAILY ACTIVITIES: Please describe your hobbies, interests, social life and volunteer work. Please include how you handle stress.

SEXUAL HISTORY: Please describe history and any concerns/issues that may impact current treatment such as: age of first sexual encounter, sexual orientation, pregnancies, birth control, traumatic experiences, extra-marital affairs, at-risk behaviors, and sexual difficulties:

Completed by: Staff Patient Other: _____

Please do not write in the Staff Section

STAFF SECTION: Reviewed

CONCLUSIONS AND RECOMMENDATIONS:

- High risk patient and/or family psychosocial issues requiring early treatment planning and immediate intervention
- Specific community resources / support systems
- Anticipated discharge plans

See initial assessment

Signature: _____ Date: _____ Time: _____

PATIENT HISTORY - ADULT BIOPSYCHOSOCIAL FORM