

Bio-Psycho-Social Assessment- Relationship Counseling

Victor Manocchio, MSW, LCSW

6 Sunnyside Road

Tunkhannock, PA 18657

570-836-7777

NPI # 1487828554

I. Client and Home

Name: _____ Name: _____
Date of Birth: _____ Age _____ Date of Birth: _____ Age _____
Social Security #: _____ Social Security # _____
Address _____
Phone Number(s) _____

Emergency Phone Numbers _____

EAP? Circle one: yes or no. Authorization Number _____
Health Insurance _____ Subscriber Number _____
Name of Primary Insured _____ d.o.b. _____
Address of Primary Insured (if different than your own) _____
Authorization Number (if required) _____
Phone number for Mental Health (found on back of card) _____

SECTION (A)

Please fill in the following table:

Who lives in the home?

Name	Relationship to the Client	Date of Birth	Highest level of Education

II. Strengths Assessment – Client and Family

What are your strengths? _____

Spouse's strengths: _____

What are the family's (as a unit) strengths? _____

Is there extended family support? Describe: _____

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Describe the importance of spirituality (relationship with Creator) and/ or religion (institution) in your life and family (if any): _____

Describe any cultural/ ethnic factors which may impact on treatment: _____

III. Presenting Problem

Please state why both of you are seeking mental health services. (i.e., Why are both of you here?)

What areas of your (both of you) life is this problem affecting? _____

How long have these issues been present (weeks, months, years)? _____

Have either of you ever received services anywhere before? _____

If so, where (include dates and length of service)? _____

Was it helpful? _____

Are there any other agencies involved with the client at this time? _____

Are there any community support groups (church, sports, Methodist Women's Association, Alcoholics Anonymous, Moose Lodge, Masons, etc.) _____

Please list those events, situations, and problems that are causing stress for the clients and his/ her family.

How have either of you tried to resolve the problem prior to coming here? _____

Why are both of you seeking help at this particular time? _____

What has changed (if applicable) that the client (or client's family) needs help? _____

Suicidal Ideation? (If so, plan, seriousness?) _____

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_____ **Homicidal or Suicidal thoughts?** _____

_____ **History of homicide/ suicide attempts?** _____

_____ Have either of you ever been hospitalized before for mental health reasons? _____

IV. Family or Marital History

Marital Status? Married Single Divorced Widowed Other

Describe the relationship with your spouse or significant other. _____

_____ Describe the relationship between client and others in the house: _____

_____ Are both of you satisfied with the level of sexual intimacy between the two of you? _____

Is there a family history of mental illness [i.e., mood problems, mental retardation, schizophrenia, psychosis, or problems with attention, activity and impulse (especially as a child)]? If so, please explain.

_____ The strengths of this relationship: _____

_____ Needs or Concerns in this relationship: _____

_____ History of Domestic Violence (verbal or physical) in any of your relationships? _____

_____ Communication Problems (past and present)? _____

_____ How many times have you separated and gotten back together with your current partner?

_____ Briefly describe the average argument in your current relationship: _____

V. Socio-Economic Data: Without telling me how much both of you make, please pick one of the following options that may describe your current financial situation. (Put an "X" at the appropriate choice.)

1. I am not worried about my bills. I have more than enough to meet my needs each month.

2. I am not worried about the bills. However, paying for everything is a little tight.

3. I am barely scraping by. My family has to be creative in order make sure we have the basics.

4. Our basic needs are barely met. I am thinking about declaring bankruptcy. I feel like we will have to do "macaroni and cheese" every night for a while, so that we have food on the table.

5. I am in danger of losing everything, including our house. I am desperate to some way to provide for my family.

VI. Trauma and Abuse (if this section applies to both clients – please delineate this)

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Have either of you ever been the victim of, or is suspected to be the victim of abuse (physical, sexual, or emotional) or neglect? Please explain: _____

Have either of you ever been accused of being the perpetrator of abuse, neglect, or domestic violence?

Have either of you ever experienced any other traumas (experiencing or witnessing domestic violence, serious illness, death of a loved one, being kidnapped, held hostage, threatened with weapons, victim of stalking, witnessing a murder, a fire, 9/11/01, etc.)? Please explain: _____

Did either of you react to this trauma with a sense of fear, helplessness, or horror to this traumatic event? (This may be exhibited in younger children by disorganized, agitated behavior): _____

Did either of you react to the trauma by spacing out: blank, frozen, numb expression/ reactions; excessive daydreaming, or excessive preoccupation with fantasy? _____

Did either of you deny or downplay the impact of a severe trauma and/ or did either of you avoid thoughts, feelings, conversation, activities, places, or people that arose recollection of the trauma?

Did either of you experience psychological panic or anxiety when reminded of the trauma and/ or physical upsets (headaches, stomach, etc.) at reminders of the trauma? _____

Did either of you experience low self-worth (self-esteem), at reminders of trauma? _____

Did either of you exhibit inappropriate sexualized behavior, excessive aggression, or separation anxiety after exposure to this trauma? _____

VII. Drugs and Alcohol (Addictions):

Do the clients/ family members smoke? How much? _____

Do you/ family use alcohol? How much and how often? _____

Do you/ family members use drugs (illegal, over-use of prescribed, or non-prescribed, etc.)? If so who? What Drugs? How much and how often? _____

Do you/ family members gamble? If so, expound: _____

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Have you/ family members ever received Drug and Alcohol Treatment? (rehab, I.O.P., outpatient, etc.)

VIII. Military Background

Have either of you/ family ever been in the military? _____

If so, what rank? _____

What branch? _____

How many years and where did they serve? _____

How were they discharged? Honorable/ Dishonorable? _____

Other comments: _____

IX. Medical Background. (Please list background for both clients)

Current Medications, Vitamins and Supplements (Topical and Oral):

Name of Medication	Dosage	How many times per day?	Prescribing Physician

General Health Status: _____

Name address phone of family doctor: _____

When was your (both of you) last physical exam? _____

In the past 6 months, any changes in sleeping patterns? _____

How many hours (average) of sleep do both of you get per night? _____

History of Chemical Dependence (drug addiction/ substance abuse)? _____

Allergies: _____

Any neurological disorders (diagnosed by a neurologist)? _____

Any known Intellectual Deficits and Disabilities (formerly known as Mental Retardation)?

Vision or Hearing Impairment? _____

Present/Past Significant Illnesses or Injuries and Treatment Received: _____

Impact on life/ family _____

Physical Limitations: _____

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Date of Arrest	Charge	Sentence	Probation	Date released

Work History

Do either of you currently work? _____ If no, why not? _____

What are your current job(s)? _____

How long have you been at the current job? _____

How many jobs have you had in the past 10 years? _____

In the last 2 years, how many months have you worked? _____

Reason for terminating employment _____

Have you ever been fired or laid off? If so, how many times? _____

Educational History:

Highest completed _____ Average grades (high, avg. low, failing) _____

Need special supports (gifted, learning, emotional) _____

Behavior Issues (detentions, suspensions, expulsions) _____

How often did you see the nurse? _____

Sexual History (both of you):

What is your primary sexual orientation? _____ Gender Identity: _____
_____ Heterosexual - (i.e. straight) _____ Cis-gender (same as birth)
_____ Homosexual - (i.e. gay) _____ Transgender (different from birth)
_____ Bisexual _____ If not cis-gender, preferred pronoun? _____

Are there other sexual orientation/ gender identity issues that should be noted? _____ At what age

did both of you become sexually active? _____

Age both of you entered puberty? _____

Do the clients have any children? _____

Where do the children live? _____

If female, how many miscarriages and abortions, if any? When? _____

Do you view/ watch pornography? If so, how many hours per day/ week? _____

Are there any other sexual history/ issues that should be noted? _____

Is there any thing else that I should know about? _____

XII. Goals

What do both of you hope to gain from these sessions in:

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(A) One month _____

(B) Three months _____

(C) Six months _____

What is your long-term goal for treatment? _____

We accept cash, personal checks, credit cards (MC, Visa, American Express, Discover), FSA and HAS debit cards. Please note there is a 4% convenience fee for using credit and debit cards.

We require 24Hour notification for cancelation of appointment. A fee of \$60 will be assessed for all no-shows and all cancelations made with less than 24Hour notification. Future appointments will not be made until account is brought current and this fee is paid in full or payment arrangements are made.

Please initial the following:

I understand that fee is due at time of service: _____

I understand that there is a 4% convenience fee for using credit and debit cards: _____

I understand that there is a \$60 fee for all no-shows and appointments canceled with less than 24Xhours notice and that future appointments will not be made until this fee is paid in full: _____

I understand that there is a \$50 service fee for all returned checks: _____

Patient signature _____ Date _____

Patient signature _____ Date _____

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Assessment of Client and Family History (OFFICE USE ONLY)

DIAGNOSIS:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

Victor J. Manocchio, MSW, LCSW

Date