Biopsychosocial Assessment Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A biopsychosocial assessment examines a client's presenting problem across biological, psychological, and social domains and ties the findings together in one synthesis. It anchors the diagnosis, level of care, and treatment plan, and the rest of the chart builds on it.

Identifying information & referral one header block, findable in seconds
Do: put client identifiers, date, clinician, referral source, service type, and start/stop times together at the top.
Pitfall: scattering these details through the narrative; reviewers and records staff hunt for them later.

Presenting problem why now, in the client's frame
Do: capture the client's own words plus onset, duration, severity, and what prompted the contact.
Pitfall: recording only your clinical rephrasing; a short quote anchors medical necessity.

Biological domain the body's contribution
Do: cover medical conditions, medications, allergies, developmental history, family medical and psychiatric history, sleep, appetite, pain.
Pitfall: a checkbox pass; unassessed medical contributors quietly undermine the whole formulation.

Psychological domain history and pattern, not a symptom re-list
Do: record psychiatric history, prior treatment and what worked, a trauma overview, coping style, and the current course.
Pitfall: restating the presenting problem here, or recording trauma detail past clinical need.

Social domain the life around the symptoms
Do: record relationships, housing, education, work and finances, legal involvement, cultural and spiritual factors, supports.
Pitfall: bare circumstances with no clinical meaning attached; say what each fact does to the presentation.

Substance use an explicit screen, every time
Do: ask about substances, pattern, frequency, most recent use, and past problem use or remission, and record the answers.
Pitfall: burying substance findings inside the social history; reviewers expect a screen they can find.

Risk screen ask, and record the answer either way
Do: document suicidal ideation, self-harm, and harm to others (current and history), protective factors, and any action taken.
Pitfall: leaving risk blank when findings are negative; the record should show you asked.

Mental status & measures observations plus baseline scores
Do: note appearance, speech, mood, affect, thought process, insight, judgment; score baselines such as the PHQ-9, GAD-7, or AUDIT-C.
Pitfall: template MSE strings that contradict the narrative, such as "euthymic mood" above a tearful presentation.

Strengths & supports what is working
Do: record coping that has succeeded, relationships, motivation, and community, and carry them into the plan.
Pitfall: a token line ("client is resilient") that never reaches the recommendations.

Integrated summary, impression & recommendations the section that makes it an assessment
Do: synthesize how the three domains interact to produce and maintain the presentation, then let diagnosis, level of care, and referrals follow.
Pitfall: data collection without synthesis; an assessment that ends at the last checkbox is a questionnaire.

Before you sign

- [ ] Integrated summary synthesizes, not repeats
- [ ] Risk screen written out, even when negative
- [ ] Every domain assessed, never assumed
- [ ] Client's words anchor the presenting problem
- [ ] Strengths documented and used in the plan
- [ ] Recommendations trace to documented findings
- [ ] Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets after the interview: presenting quote, key findings per domain, substance and risk status, scores, impression, recommendations.

"Draft a biopsychosocial assessment from these bullets, adult referred by PCP for depression after a job loss, PHQ-9 16, alcohol use disorder in sustained remission: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

600–1,500 words	45–75 min by hand	At admission	Care team · payers · auditors
typical length	clinical team estimate	and higher levels of care	who reads it

Full guide and sample note:
bastiongpt.com/template/biopsychosocial-assessment

BastionGPT drafts the assessment from your interview bullets. Free 7-day trial.

Biopsychosocial Assessment Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): | DOB / age: | Date: | Start/stop times:

Clinician / credentials: | Referral source: | Service: biopsychosocial assessment

Presenting problem
In the client's words, plus onset, duration, severity, precipitant

Biological domain
Medical conditions, medications, allergies, developmental history, family medical and psychiatric history, sleep, appetite, pain

Psychological domain
Psychiatric history, prior treatment and response, trauma overview, coping style, current symptoms and course

Social domain
Family and relationships, housing, education, work and finances, legal, cultural and spiritual factors, supports

Substance use
Substances, pattern, frequency, most recent use, past problem use and remission

Risk screen
SI, self-harm, harm to others (current and history); protective factors; action taken

Mental status observations
Appearance, speech, mood, affect, thought process, insight, judgment

Strengths, supports & measures
Coping that works, relationships, motivation, community; baseline scores (e.g., PHQ-9, GAD-7, AUDIT-C)

Integrated summary
How the biological, psychological, and social findings interact; why this person, why now

Diagnostic impression & recommendations
Provisional diagnosis with rule-outs; level of care, referrals, initial plan, next appointment

Consent reviewed and signed: Y / N | Clinician signature / credentials: | Date signed: