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Adult Biopsychosocial Medical Questionnaire

Please provide the requested information on yourself or the person for whom you are completing the questionnaire. Please respond to *all* questions.

Identifying Data:

Name: _____ Birth Date: ___/___ /___ Age: _____ Sex: _____

Address: _____
Street City State Zip Code

Phone Numbers:

Home: (____) _____ Work: (____) _____

Cell: (____) _____ Emergency: (____) _____

What prompted you to seek assistance at this time:

_____

_____

How long has this situation been a problem or concern for you?

_____

How did you hear about Mary Petersen?

_____

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Is there **any chance** that you are currently pregnant? ☐Yes ☐No ☐Unsure ☐N/A

If you are pregnant, are you receiving prenatal care? ☐Yes ☐No ☐N/A

Family/Cultural lnformation:

Birth Place: _____ Place Raised: _____

Who raised you? _____

№ of Family Members: _____ Brothers: _____ Sisters: _____

Your birth order number: _____

Parents Current Marital Status: _____

If parents divorced, how old were you at the time? _____ Who raised you after the divorce? _____

Father's age now: _____ Father's Occupation: _____ Father's age at death: _____

Mother's age now: _____ Mother's Occupation: _____ Mother's age at death: _____

Describe your current relationship with: (If deceased, describe relationship before death)

Father: _____

Mother: _____

Brothers & Sisters: _____

State your impressions regarding childhood and adolescence:

_____

_____

Educational History

Highest level of education: ☐ High School Graduate ☐ Still in school, What grade are you in: _____
☐ Some College Credits: _____ ☐ College Graduate Degree _____
☐ Dropped out of school Reason: _____

Highest grade completed?_____ Are you satisfied with your level of education? ☐ Yes ☐ No

If "No," Why are you not satisfied? _____

State any educational goals: _____

Religious/Spiritual Background

Do you practice your religion: ☐ Regularly ☐ Occasionally ☐ Never

What is you current religious preference/affiliation: _____

Do you believe in God/Higher Power? ☐ Yes ☐ No

Have you **ever** participated in any type of self-help/support group (AA, NA, Al-Anon, RR etc.)?

If you answered yes above, what is your opinion regarding meetings? _____

_____

If you have been to support groups before, how long has it been since you have been to a meeting?_____

Vocational/Military Background
Have you served in the armed forces? ☐ Yes ☐ No Years: _____ Branch: _____

Have you had combat experience? ☐ Yes ☐ No Discharge Status: _____

Are you currently employed? ☐ Yes ☐ No If employed, for how long at present job: _____

Job Title/Position: _____ Are you satisfied with your work? _____

Job History:

Type of Work	Length of Employment	Reason for Leaving	Degree of Satisfaction

Do you have any specialized vocational training? ☐ Yes ☐ No

What type of training?_____

lf you experience any problems with employment state them: _____

Marital Status

Current Marital Status: ☐ Single (Never Married) ☐ Dating Seriously ☐ Dating Casually ☐ Engaged
☐ Unmarried, living with somone. Duration of the relationship: _____
☐ Married ☐ Separated ☐ Divorced ☐ Widowed

I live: ☐ Alone ☐ With Friends ☐ With Parents ☐ With Partner ☐ Other: _____

Check the box which best describes your present relationship with your partner:
☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor ☐ Very Poor ☐ I am not currently in a relationship

Please describe any concerns about your current partner: _____

_____

Marriages

Date Married	Age	Date Divorced	Age	Reason	Nº of Children

Children

Name	Age	Lives With	Quality of Relationship	Problems or Concerns

Social and Sexual Background

I consider myself to be: ☐ Heterosexual ☐ Gay/Lesbian ☐ Transgender
☐ Bisexual ☐ I am uncertain about my sexuality

Have you ever been: ☐ Sexually Abused ☐ Physically Abused ☐ Emotionally Abused

By whom? _____

Age when abused: _____ Duration of Abuse: _____

Describe briefly what happened: _____

_____

Have you experienced any sexual dysfunction: ☐ Yes ☐ No

Describe dysfunction: _____

_____

With whom do you spend MOST of your time: ☐ Family ☐ Friends ☐ Acquiaintances ☐ Alone

How often do you see your friends/acquaintances: ☐ Daily ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

Do you have a best friend outside of your family? ☐ Yes ☐ No

How often do you see that person? _____

How many close friends do you have? _____ How many acquaintances do you have? _____

What do you and your friends/acquaintances typically do together? _____

Leisure Time/Interests

List any hobbies, interests, or social talents: _____

Do you participate in your hobbies etc: ☐ Regularly ☐ Sometimes ☐ Irregularly ☐ Rarely ☐ Never

Has your use of leisure time changed in the past year? ☐ Yes ☐ No

If yes, describe changes: _____

_____

Describe your typical day: _____

_____

Financial Factors

Do you currently have financial problems? ☐ Yes ☐ No

Are your problems: ☐ Very serious ☐ Serious ☐ Not so serious ☐ Can handle them

What have you done to solve them? _____

_____

Legal Status

I am currently: ☐ On probation ☐ On parole ☐ Awaiting charges ☐ Awaiting trial/sentence
☐ No police involvement ☐ Former legal issues, currently resolved

How many times have you been arrested in the last 5 years? _____ In the last 6 months? _____

Charges	Date	Outcome	Alcohol/Drug Related
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Are you being asked to refrain from the use of substances as part of your probation order? ☐ Yes ☐ No ☐ Unsure
Are you receiving drug and/or alcohol testing as part of your probation experience? ☐ Yes ☐ No ☐ Unsure

Medical/Health History

Do you have a routine health care provider (non-emergency room)? ☐ Yes ☐ No

If so, please provide the doctor/practice name, phone number and city where the office is located:

_____

Have you had a physical exam in the last two years ☐ Yes ☐ No
(Or the last one year if you are over 40 years of age)?

Do you have any current medical complaints or recurring physical symptoms/pain that you are not receiving medical attention for? ☐ Yes ☐ No

Do you have any current physical impairments or disabilities that you are not receiving medical attention for? ☐ Yes ☐ No

Hospitalizations/Surgery in last 5 years

Problems	Year/Age	Outcome

Major Illness in last 5 years

Problems	Year/Age	Outcome

Any previous Mental Health treatment

Problems	Year/Age	Outcome

Name/Location of previous therapist

_____

Reason you have not returned to previous therapist _____

Do you presently feel suicidal: ☐ Yes ☐ No Do you presently feel homicidal: ☐ Yes ☐ No

Have you ever attempted to or had serious thoughts of suicide or of hurting other people? ☐ Yes ☐ No

If so, when did this happen and what was the outcome?

_____

List any current medications that you take for any reason:

Type/Name/Dosage	Why do you take it?	Who prescribes this for you?

Any Accidents/Injuries in the last 12 months:

Type	Year/Age	Outcome

For the last month I have been: ☐ Sleeping too much ☐ Not sleeping enough ☐ Getting the right amount of sleep

I currently experience: ☐ Trouble getting to sleep ☐ Frequent waking ☐ Early rising
☐ Trouble waking up ☐ None of these problems

Have your sleeping habits changed in the last 6 months? ☐ Yes ☐ No

If so, how? _____

For the last month I have been: ☐ Under eating ☐ Starving myself ☐ Over eating ☐ Eating with no trouble

I eat: ☐ A well balanced diet ☐ Junk food ☐ Fast foods ☐ Whatever is available, without thought

Have your eating habits changed in the last 6 months? ☐ Yes ☐ No

If so, how? _____

Have you used **any** alcohol or drugs **in the last 30 days** that were not prescribed for you? ☐ Yes ☐ No

Have you used any drugs by injection **in the last 10 years?** ☐ Yes ☐ No

If so, when was the last time and which drug(s) were you injecting? _____

When was the last time you used **any** drugs or alcohol?_____

Do you live with any people who use alcohol or other drugs? ☐ Yes ☐ No

If so, what concerns (if any) do you have about this? _____

What kinds of problems (if any) has alcohol or other drug use caused in your life to date?

_____

Do you smoke cigarettes? How much? _____

Please place a check mark in the box of any substance you have used in the last 12 months. In the space following each drug, please mark the number of days you have used each drug in the last 30 days:

Used?	Days used in the last 30 days	Used?	Days used in the last 30 days	Used?	Days used in the last 30 days
☐ Alcohol		☐ Opiates/Herion		☐ Steroids	
☐ Marijuana		☐ Sedatives		☐ Pain Killers	
☐ Cocaine		☐ Amphetamines		☐ Hallucinogens	
☐ Crack		☐ Inhalants		☐ Other	
☐ Ecstasy		☐ GHB			

What is your preferred substance? _____

Do you use substances while: ☐ Alone ☐ With others ☐ Both

Additional Information: Do you have anything to add to this information:

_____

_____

Current Symptom Checklist

Are you presently aware of having any of the following conditions? Check any that apply:

☐ appetite disturbance	☐ physical pain	☐ problems with concentration
☐ sleep disturbance	☐ thyroid problems	☐ boredom
☐ elimination disturbance	☐ shortness of breath	☐ social isolation
☐ fatigue/low energy	☐ tension	☐ worthlessness
☐ psychomotor retardation	☐ physical numbness	☐ problems with memory
☐ poor grooming	☐ heartburn	☐ excessive worry/anxiety
☐ unexplained hair loss	☐ chest pain/tightness in chest	☐ bingeing/purging
☐ hypoglycemia	☐ seizures	☐ depressed mood
☐ diabetes	☐ laxative/diuretic abuse	☐ mood swings
☐ irregular heart rhythm or murmur	☐ anorexia	☐ agitation/irritability
☐ mitral valve prolapse	☐ paranoia	☐ guilt
☐ diarrhea	☐ delusions	☐ shame
☐ dizziness	☐ phobias	☐ anger
☐ overweight	☐ intrusive thoughts/memories	☐ resentment
☐ hyperactivity	☐ hallucinations (auditory, visual or both)	☐ hostility
☐ somatic complaints	☐ aggressive behaviors	☐ panic attacks
☐ significant weight gain/loss	☐ conduct problems	☐ generalized anxiety
☐ concomitant medical condition	☐ obsessions/compulsions	☐ feeling “disconnected”
☐ physical trauma victim	☐ sexual dysfunction	☐ jitteriness
☐ ulcers	☐ dissociative states	☐ lump in throat
☐ skin eruptions	☐ self-mutilation	☐ grief
☐ high blood pressure	☐ sexual trauma victim	☐ hopelessness
☐ pregnancy	☐ substance abuse	☐ elevated mood
☐ recent abortion	☐ feelings of smothering or choking	☐ emotional trauma victim
☐ recent delivery of baby	☐ night sweats	☐ emotional numbness
☐ PMS	☐ blurred vision	☐ crying too much
☐ menopause	☐ nightmares	☐ feel like crying but unable to

_____ _____

Signature of Person Providing Information Date

_____

Relationship to Patient

I have reviewed this questionnaire with the patient/client:

_____ _____

Therapist Signature and Credentials Date