

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: _____

City _____ State _____ Zip Code _____

Phone Numbers:

Home/Cell: _____ Work: _____ 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 information:

Birth Place: _____

Place Raised: _____

Who raised you? _____

Number 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? _____

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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: Current Grade Level: _____ 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 your 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? Yes No

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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? _____

If you experience any problems with employment state them: _____

Marital Status

Current Marital Status: Single (Never Married) Dating Seriously Dating Casually Engaged

Unmarried, living with someone. 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 Acquaintances _____ 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 |
|---------|------|---------|--|
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> 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

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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? _____

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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? Yes No How much? _____

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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 |
|------------------------------------|-------------------------------|---|-------------------------------|--|-------------------------------|
| <input type="checkbox"/> Alcohol | | <input type="checkbox"/> Opiates/Herion | | <input type="checkbox"/> Steroids | |
| <input type="checkbox"/> Marijuana | | <input type="checkbox"/> Sedatives | | <input type="checkbox"/> Pain Killers | |
| <input type="checkbox"/> Cocaine | | <input type="checkbox"/> Amphetamines | | <input type="checkbox"/> Hallucinogens | |
| <input type="checkbox"/> Crack | | <input type="checkbox"/> Inhalants | | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Ecstasy | | <input type="checkbox"/> 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:

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

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Signature of Person Providing Information _____ Date _____

Relationship to Patient _____

I have reviewed this questionnaire with the patient/client:

Therapist Signature and Credentials _____ Date _____