

Parent Biopsychosocial Medical Questionnaire

Please provide the requested information. Please respond to all questions.

Identifying Data:

Parents' Names: _____

Client Name: _____

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

Address: _____

Phone Numbers:

Home/Cell: _____ Work: _____ Emergency: _____

What prompted you to seek assistance for your child at this time? _____

How long has this situation been a problem? _____

How did you hear about Mary Petersen? _____

Has your child ever been to another therapist before for any reason? _____

If so, when, and why? _____

Family/Cultural Information: (Please check all that apply):

Race: Caucasian Black Hispanic Asian Native American Other: _____

Where was your child born? _____

Who is raising your child? _____

Number of Brothers: _____ Number of Sisters: _____

What number (in the birth order) is your child? _____

Parents' current marital status? _____

If parents are deceased, how old was the child at the time? _____

If parents are divorced, how old was the child at the time? _____

How did the child deal with the divorce? _____

Describe your impression of your child's current relationship with:

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Father: _____

Mother: _____

Brothers/Sisters: _____

Can your child talk to mom, dad, brothers, or sisters about problems? Yes No

Has your child had problems following house rules? Yes No

Are there consequences set by you when your child disobeys house rules? Yes No

Has your child ever run away from home? Yes No

To your knowledge, has your child ever snuck out of the house? Yes No

Does your child have a curfew? Yes No

Does he/she follow it? Yes No

Does your child have chores? Yes No If so what? _____

Is there anything you would like to see change at home? Yes No

Educational History:

Your child's Highest Level of Education:

Still in school? What grade? _____

What school does your child go to? _____

High School Graduate? GED Completion? Some College? _____

Dropped out of school? _____ Reason: _____

Highest Grade Completed? _____

School Performance (Check one):

A-B Student B-C Student C-D Student Failing

Has your child ever been suspended from school? Yes No

Has your child ever been expelled from school? Yes No

Has your child ever repeated a grade? Yes No

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Has your child ever been enrolled in special education classes? Yes No

To your knowledge, does your child have trouble concentrating, understanding, or remembering? Yes No

Does your child like school? Yes No

What leads you to believe this? _____

What do you think would make school better for your child? _____

Please state any educational concerns: _____

Religious/Spiritual Background:

Is your child involved with a religion? Yes No

What religion? _____

Do you practice your religion regularly irregularly never?

Work History:

Does your child currently have a job? Yes No

If so, where, and doing what? _____

How many hours a week does he/she work? _____

Do you believe your child likes his/her job? Yes No

Do you believe there are any problems at work? Yes No

Does your family currently have financial problems? Yes No

Social/Sexual Background:

With whom does your child spend MOST of his/her free time? Circle all that apply:

Family Friends Acquaintances Alone

How often does your child see friends/acquaintances?

Daily Frequently Occasionally Rarely Never

Do you approve of your child's friends and activities? Yes No

To your knowledge, has your child been teased a lot by other kids? Yes No

Has your child recently changed his/her circle of friends/best friend? Yes No

Does your child have trouble making or keeping friends? Yes No

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Has your child been involved in a serious relationship that may include sexual activity? Yes No

Are you concerned about any intimate relationships that your child has had/is having? Yes No

To your knowledge, has your child had any pregnancies or gotten any person pregnant? Yes No

If so, what was the outcome? _____

To your knowledge, does your child use any birth control or
precautions to prevent pregnancies or sexually transmitted diseases? Yes No

To your knowledge, has your child ever been involved in any gang activity? Yes No

Leisure Time/Interests:

List your child's hobbies, interests, talents, or school activities: _____

How often does your child participate in hobbies: (check one)

Regularly Sometimes Irregularly Rarely Never

Has your child's use of free time changed in the past year? Yes No

Medical/Health History:

Do you have a family doctor or other regular health care provider? Yes No

Has your child had a physical exam in the last year? Yes No

Does your child have any current physical problems, symptoms, or pain that he/she is not receiving medical attention for? Yes No

How would you describe your child's development,
from the pregnancy and delivery through childhood? _____

Do you have health insurance? Yes No

List any medications that your child is taking:

Medications _____

Reason for Taking It _____

Who Prescribes It _____

Has your child's eating or sleeping changed in the last year? Yes No

How? _____

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In the last month, which of the following applies to your child? (Check all that apply)

- Sleeping too much Not sleeping enough Getting the right amount of sleep
- Trouble getting to sleep Frequent waking Early rising No sleep problems
- Under-eating Starving themselves Over-eating Eating with no trouble
- Well-balanced diet Junk food/fast foods Whatever is available without thought

To your knowledge, has your child ever been:

- Sexually Abused? Physically Abused?

By Whom? _____

How old was your child at the time of abuse? _____ How long did the abuse last? _____

Did he/she receive help for this? Yes No

To your knowledge, does your child feel suicidal now, or has your child ever felt suicidal in the past? Yes No

Do you feel that your child might hurt others? Yes No

Has your child ever attempted or suicide or hurt other people? Yes No

If so, when, and how? _____

Has your child ever had any major illnesses, hospitalizations, surgery, accidents, or injuries? Yes No

If so, please explain _____

Legal Status:

Does your child now, or has your child ever had any legal problems? Yes No

Has your child ever been in a youth home? Yes No

Have your child ever been arrested or ticketed? Yes No

What was the charge? _____

Is your child currently:

- On probation Awaiting charges Awaiting trial/sentence No police involvement

Have you or your child ever been involved with protective services? Yes No

Alcohol/Drug Use:

Does your child smoke cigarettes? Yes No How much? _____

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Is he/she allowed to smoke in the house? Yes No

What kinds of problems, if any, have drugs/alcohol caused in your child's life? _____

Additional Comments

Do you have any other comments? _____

Signature of Parent/Guardian _____ Date _____

I have reviewed this information with the client's parent/guardian.

Signature of Therapist _____ Date _____