Client Name:
_____

Lake Orion Counseling Center, P.C.
BioPsychoSocial Questionnaire – Adults

Name: _____ Preferred Name: _____
E-Mail:_____ SOC#: _____
Address: _____ City: _____
STATE: _____ Zip: _____ Telephone (H): _____ (W): _____
(C): _____ Birth Date: _____ Age: _____ Sex: _____
Height: _____ Weight: _____ Any recent changes in weight? Yes: _____ No: _____
Emergency Contact: _____ Telephone: _____
Please indicate the primary reason for seeking therapy and what you hope to accomplish through therapy:_____
_____
Please estimate the severity of your problem:
_____ Mildly upsetting ___Moderately upsetting ___ Severely upsetting ___ Totally incapacitating
Have you been in therapy for mental health problems in the past? _____Yes _____No
If yes, please explain (provide details including where/when/results/medications): _____
_____
_____

Family History

Father: Name: _____ Age: _____
Occupation:_____ Education:_____ Health:_____
If deceased, give his age at time of death:_____ How old were you at the time:_____
Cause of death:_____
Mother: Name:_____ Age:_____
Occupation:_____ Education:_____ Health:_____
If deceased, give her age at time of death: _____ How old were you at the time:_____
Cause of death:_____
Describe parent's relationship with each other: _____
_____
Stepparent History (i.e. your age when each parent remarried): _____
_____
With whom did you live while growing up? _____
_____
Where did you grow up? _____

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Did you move around? _____

# of Siblings: _____ Your Birth Order: _____

Names of siblings: _____

_____

_____

Describe your overall relationships with your siblings: _____

_____

_____

For any deceased Brothers and Sisters:

Name	Cause of death	Age at Death

Describe your mother's (or substitute's) personality and her attitude toward you (past and present):

_____

_____

_____

_____

Describe your father's (or substitute's) personality and his attitude toward you (past and present):

_____

_____

_____

Describe your relationship with any stepparents:_____

_____

_____

_____

In what ways were you disciplined or punished by your parents? _____

_____

_____

Was the discipline/punishment fair and evenly distributed among your siblings? _____ Yes _____ No

Were you able to confide in your parents? _____ Yes _____ No

Did you feel loved and respected by your parents? _____ Yes _____ No

Has anyone (parents, friends, relatives) interfered in your marriage, occupations, etc? __ Yes ___ No

If yes, please briefly describe: _____

_____

Do you have difficulties asking them for help? _____ Yes _____ No

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Age when you moved out of your parent's home? _____

Check any of the following that occurred during your childhood/adolescence:

___ Happy Childhood	_____ Not many friends	_____ Sexually abused
___ Unhappy Childhood	_____ School problems	_____ Severely bullied or teased
___ Eating disorder	_____ Medical problems	_____ Emotional/behavior problems
___ Legal trouble	_____ Financial difficulties	_____ Strong religious beliefs
___ Death in the family	_____ Feeling ignored	_____ Severely punished
___ Used alcohol	_____ Drug use	_____ Parental drug/alcohol abuse

___ Other: _____

_____

EDUCATION and EMPLOYMENT

Overall attitude and experience with school: _____

_____

Parent's attitude/involvement with your education: _____

_____

Biggest difficulties in school: _____

_____

How did you deal with it? _____

_____

Biggest area of strength in school: _____

_____

What is the highest grade you completed? _____ G.E.D.? _____
List any college degrees or vocational certificates: _____

_____

Are you satisfied with your education? _____ Yes _____No
If no, why not? _____

_____

Are your currently employed? _____Yes _____No
If yes, where? _____ How Long? _____
Job Title: _____ Are you satisfied with your job? _____ Yes _____ No
Please Explain: _____

_____

Previous Employment History: _____

_____

_____

Longest held job: _____ Duration:_____
Military Services? _____ Yes _____ No Branch: _____ Years: _____ Discharge Status:_____

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What is your spouse/significant other's vocational status: _____
_____

Interpersonal Relationships:
Do you make friends easily? _____ Yes _____ No Do you keep them? _____ Yes _____No
Did you date much during high school? _____ Yes _____ No

Social Relationships

Describe your friendships _____ I have no friends _____ I have close friends
_____ I have only acquaintances ___I have both acquaintances and friends
How often do you see them? _____Daily ___ Frequently ___ Once in a while _____Infrequently
Describe any relationship that gives you:
Joy: _____
_____
Anger: _____
_____
Anxiety: _____
_____

Please rate your level of comfort in social situations:
Very relaxed 1 2 3 4 5 6 7 Very anxious

Do you have one or more friends with whom you can relax and share private thoughts? __ Yes __ No
Are you able to ask friends for help? ___ Yes ___ No
Do you rate your relationships as satisfying? _____ Yes _____ No

Leisure Time

How do you spend most of your leisure time? _____Alone _____With others _____ About Equal
List your hobbies, leisure time activities, interests and talents: _____
_____
_____
Have your leisure activities changed in the last two years? _____Yes _____ No
If yes, explain how: _____
_____
Have you lost interest in the things you used to enjoy doing? Yes: _____ No: _____

Marriage (or a committed relationship)
Current marital status _____ Married _____ Separated _____ Divorced _____ Widowed _____ Single
If married, how long did you know your spouse before your engagement? _____
How long were you engaged before you got married? _____
How long have you been in your current relationship? _____
What is your partner's name? _____ Age? _____ Occupation?_____
Describe your partner's personality: _____

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_____
What do you like most about your partner? _____
_____
What do you like least about your partner? _____
_____
What interferes with your relationship satisfaction? _____
_____
Please list previous marriages/durations: _____
_____
What is the longest relationship you have been in? _____ If it ended, why did it end? _____
_____
Any significant details about previous marriages/relationships? _____
_____
Please rate your current level of relationship satisfaction:
Very dissatisfied 1 2 3 4 5 6 7 Very satisfied

Are you satisfied with the level of intimacy in your relationship? _____ Yes _____ No
Do you have children? _____ Yes _____ No If yes, how many? _____
Do you have children from previous relationships? _____ Yes _____ No If yes, how many? _____
What are the names and ages of any children? _____
_____
_____
Do any of your children present special problems/challenges? _____ Yes _____ No
If yes, please describe: _____
_____
_____
_____

Sexual relationships
Describe your parents' attitudes toward sex. Was sex discussed in your home? _____
_____
When and how did you derive your first knowledge of sex? _____
_____
Do you experience any discomfort regarding your sexual orientation? _____ Yes _____ No
Any relevant details regarding your first or subsequent sexual experiences? _____
_____
Is your present sex life satisfactory? _____ Yes _____ No
If no, please explain: _____
_____
Please note any sexual concerns not addressed above: _____
_____
Have you ever been physically or sexually abused? _____ Yes _____No
Have you ever physically or sexually abused anyone? _____ Yes _____ No

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Other relationships

Are there any problems in your relationships at work? _____ Yes _____ No
If yes, please describe: _____
_____
Please complete the following:
One of the ways people hurt me is: _____
_____
I could shock you by: _____
_____
My best friend thinks I am: _____
_____
My significant other would describe me as: _____
_____
People who dislike me say: _____
_____
When I am upset I am most likely to respond by: _____
_____

Biological Information
Do you have any concerns about your current physical health? _____ Yes _____ No
If yes, please explain: _____
_____
_____
Please list any significant medical problems that apply to you or members of your family: _____
_____
_____
Please list any surgeries and dates: _____
_____
_____
Please list any physical handicaps: _____
_____
Are you satisfied with your appearance and abilities? _____ Yes _____ No
If no, please explain: _____
_____
_____
Do you have any difficulties sleeping? _____ Yes _____ No Falling or staying asleep? _____
On Average, how much sleep do you get per night? _____ Are you rested when you wake? _____
Do you get regular physical exercise? _____ Yes _____ No

Drug/Alcohol History:

Do you currently drink alcohol? _____ Yes _____ No
If yes, how often? _____
Age of first use _____ How did it happen? _____
Have you ever had a bad reaction (e.g. Blackout, Shakes) from drinking alcohol? _____ Yes_____No

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If yes, please explain: _____
Last use? _____
Do you currently use drugs? _____ Yes _____No
If yes, specify type and frequency: _____
Age of first use _____ How did it happen? _____
Have you ever had a bad reaction to prescribed, over the counter or street drugs? _____Yes _____ No
If yes, please explain: _____
Last use: _____
Any family history of physical or emotion difficulties or struggles with addiction? _____ Yes _____ No
If yes, please describe: _____
_____
Have you had any experience with addiction and treatment? _____ Yes _____ No
If yes, please detail: _____
Have your parents or any other family members had mental health, alcohol or any other drug problems? _____ Yes _____ No _____ Unknown
If yes, please describe and list prior treatments: _____
_____
_____
_____

Finances

Do you currently have financial problems? _____Yes _____ No
If yes, please explain: _____
_____
_____

Legal Problems

Have you ever been involved with the police or the courts? _____ Yes _____No

If yes, please specify the following

Charge	Date	Outcome

Spiritual Assessment

Did you attend religious services with your family as a child? _____ Yes _____ No
Was religion a positive influence on you as a child? _____ Yes _____ No
Do you attend religious services currently? _____ Yes _____ No
Is spirituality a positive influence in your life today? _____Yes _____ No
Please list your cultural and ethnic background: _____
_____

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Medical Assessment

Date of most recent physical exam: _____

Do you have a disability/handicap? _____ Yes _____No

If yes, please describe: _____

Have you been diagnosed with (check all that applies)?

	Heart Disease		Pituitary Gland Disorder		Sugar Diabetes
	Cancer		Pneumonia		Allergies
	Ulcers		Gastro Intestinal Disorder		Thyroid Condition
	Asthma		High or Low Blood Pressure		Sexual Transmittable Disease
	Hypoglycemia		Pre Menstrual Syndrome		Convulsions or Seizures
	Colitis		Tested Positive for H.I.V.		Abnormal/Painful Menstruation
	Infertility		Miscarriages		Other:

Please provide dates and explanation for any checked items:_____

_____

_____

_____

Do you smoke cigarettes or use other tobacco products? ____Yes ____No If yes, how often:_____

Do you drink products containing caffeine: _____ Yes _____ No if yes, how often: _____

Please list all the medications (prescription or non-prescription) you are currently taking:

Name	Strength	Frequency

(use back if more space is needed)

For women:

Menstrual history

Age at first period: ____ Were you informed? ___ Yes ____ No Did it come as a shock? __ Yes __ No

Are you regular? ___ Yes ____ No Duration: _____ Do you have pain ____ Yes __ No

Do your periods affect your moods? ____ Yes ____ No

Do your periods affect your relationships with others? ____ Yes ____ No

Emotional Behavioral Functioning

Check any symptoms you have experienced in the past year:

	Decrease in energy		Restlessness		Hopelessness		Excessive guilt
	Panic Attacks		Cruelty		Loss of pleasure		Depressed Mood
	Anxiety		Sleep Disorder		Withdrawn		Oppositional
	Poor concentration		Indecisive		Mood swings		Violation of rules
	Legal Problems		Irritability		Helplessness		Eating disturbance
	Impulsivity		Worrying		Aggression/Rage		Tearfulness
	Substance abuse		Ritualistic Behavior		Low Self-esteem		Low Motivation
	Other:						

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_____

Risk Assessment

Suicide/Homicide Assessment:

Do you have suicidal/homicidal thoughts?	_____ Yes _____ No
Do you have suicidal/homicidal urges?	_____ Yes _____ No
Do you have suicidal/homicidal plans?	_____ Yes _____No
Have you recently made a suicidal/homicidal attempt or gesture?	_____ Yes _____No
Do you have a history of suicidal/homicidal thoughts or urges?	_____ Yes _____No
Have you made suicidal/homicidal attempts in the past?	_____ Yes _____No

Other: Please use the following space to add information you think might be helpful to your therapist that was not addressed previously:

_____ _____

Signature of Informant Date Relationship to client

I have reviewed this questionnaire with the patient/informant: _____

Clinician's Signature/Credentials Date
(Coordinator of services)