

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? _____

Client Name:

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

Client Name: _____

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

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Happy Childhood | <input type="checkbox"/> Not many friends | <input type="checkbox"/> Sexually abused |
| <input type="checkbox"/> Unhappy Childhood | <input type="checkbox"/> School problems | <input type="checkbox"/> Severely bullied or teased |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Medical problems | <input type="checkbox"/> Emotional/behavior problems |
| <input type="checkbox"/> Legal trouble | <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Strong religious beliefs |
| <input type="checkbox"/> Death in the family | <input type="checkbox"/> Feeling ignored | <input type="checkbox"/> Severely punished |
| <input type="checkbox"/> Used alcohol | <input type="checkbox"/> Drug use | <input type="checkbox"/> Parental drug/alcohol abuse |
| <input type="checkbox"/> 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 you 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)?

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

<input type="checkbox"/>	Decrease in energy	<input type="checkbox"/>	Restlessness	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	Excessive guilt
<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	Cruelty	<input type="checkbox"/>	Loss of pleasure	<input type="checkbox"/>	Depressed Mood
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Sleep Disorder	<input type="checkbox"/>	Withdrawn	<input type="checkbox"/>	Oppositional
<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	Indecisive	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	Violation of rules
<input type="checkbox"/>	Legal Problems	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Helplessness	<input type="checkbox"/>	Eating disturbance
<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	Worrying	<input type="checkbox"/>	Aggression/Rage	<input type="checkbox"/>	Tearfulness
<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>	Ritualistic Behavior	<input type="checkbox"/>	Low Self-esteem	<input type="checkbox"/>	Low Motivation
<input type="checkbox"/>	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
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I have reviewed this questionnaire with the patient/informant: _____

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