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Student Biopsychosocial Medical Questionnaire

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

Identifying Data:

Name: _____ Birth Date: __/__/__ Age: ____ Sex: ____

Address: _____

Phone Numbers:
Home: _____ Work: _____

Cell: _____ Emergency:_____

Why are you coming in for counseling at this time? _____
_____

How long has this situation been a problem for you? _____

How did you hear about Mary Petersen? _____

Have you ever been to another therapist before for any reason? _____

If so, when, and why? _____

Family/Cultural Information:

(circle all that apply):
Race: Caucasian Black Hispanic Asian Native American Other: _____

Who is raising you? _____ Who do you live with? _____

Brothers:_____ Sisters:_____ What number are you?_____

If parents are deceased, how old were you at the time?_____

If parents are divorced, how old were you at the time?_____

Describe your relationship with:

Your father:_____

Your mother:_____

Your brothers/sisters:_____

Can you talk to your mom, dad, brothers, or sisters about your problems?_____

If not, who do you talk to when you have a problem?_____

Have you had problems following house rules?_____

Are there consequences set by your parents when you disobey house rules?_____

How do you feel about this?_____

Have you ever run away from home?_____

Do you have a curfew? _____

Do you have chores?_____ If so what are they?_____

Is there anything you would like to see change at home that would make your life better?_____

Educational History:

Highest Level of Education:

Still in school? _____ What grade?_____

What school do you go to? _____

High School Graduate?____ GED Completion?____ Some College?_____

Dropped out of school?____ Reason:_____

Highest Grade Completed?_____
School Performance (circle one): A-B Student B-C Student C-D Student Failing

Have you ever been suspended from school? _____

Have you ever been expelled from school? _____

Have you ever repeated a grade?_____

Have you ever been enrolled in special education classes?_____

Do you have trouble concentrating, understanding, or remembering? _____

Do you like school?_____ Why or why not?_____

What would make school better for you?_____

Religious/Spiritual Background:

Do you believe in God or a Higher Power? _____

What is your religion?_____

Do you practice your religion regularly, irregularly, or never? _____

Work History:

Do you currently have a job? _____ If so, where?_____

What do you do at work?_____

How many hours a week do you work? _____ Do you like your job?____

Do you have any problems at work?_____

Social Background:

With whom do you spend MOST of your free time? Circle all that apply:

Family Friends Acquaintances Alone

How often do you see your friends/acquaintances?

Daily Frequently Occasionally Rarely Never

Do you have a best friend outside your family? _____

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

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

Have you ever been teased a lot by other kids?_____

Does your mom/dad/care giver like your friends?_____

Have you recently changed your circle of friends/best friend?_____

If so, what happened?_____

Do you ever feel like you do not belong?_____

Do you have trouble making or keeping friends?_____

Leisure Time/Interests:

List any hobbies, interests, talents, or school activities:_____

How often do you participate in your hobbies: (circle one)

Regularly Sometimes Irregularly Rarely Never

Has your use of free time changed in the past year?_____

Medical/Health History:

Do you have a family doctor or other regular health care provider?_____

Have you had a physical exam in the last year?_____

Do you have any current physical problems, symptoms, or pain that you are not receiving medical attention for?_____

Do you have health insurance?_____

Is there ANY CHANCE that you may be pregnant?_____

If you are pregnant, are you receiving prenatal care?_____

List any medications that you are taking:

Medication	Reason for Taking It	Who Prescribes It

Has your eating or sleeping changed in the last year?_____ How?_____

In the last month, which of the following applies to you? (Circle 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 yourself Over-eating Eating with no trouble

Well-balanced diet Junk food/fast foods Whatever is available, without thought

Have you ever been:

Sexually Abused?_____ Physically Abused?_____ Emotionally Abused?_____

By Whom?_____ How old were you?_____

How long did it last?_____ Did you receive help for this?_____

Do you feel suicidal now?_____ Have you ever felt suicidal?_____

Do you feel you might hurt others?_____

Have you ever felt you might hurt others?_____

Have you ever attempted or had serious thoughts of suicide or hurting other

people?_____ If so, when, and how?_____

Sexual Background:

Are you sexually active? (Circle one) YES NO SORT OF UNSURE

If so, do you use protection against pregnancy/sexually transmitted diseases?____

Do you consider yourself to be: Heterosexual Homosexual Bisexual Uncertain

Legal Status:

Do you have any legal problems now? _____

Have you ever had legal problems?_____

Have you ever been in a youth home?_____

Have you ever been arrested or ticketed?_____

What was the charge?_____

Are you currently:

On probation Awaiting charges Awaiting trial/sentence No police involvement

Alcohol/Drug Use:

Do you smoke cigarettes? _____ How much?_____

Are you allowed to smoke in the house?_____

Have you used ANY drugs or alcohol in the last 30 days that were not prescribed for you?_____

Have you ever used drugs by injection?_____ If so, when?_____

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

Do you live with anyone who uses drugs/alcohol?_____

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

Signature of Client_____

Date_____

I have reviewed this questionnaire with the client.

Signature of Therapist _____

Date_____