MARY PETERSEN, L.M.S.W., A.C.S.W., P.C.
20816 Eleven Mile Road, Suite 100 • Saint Clair Shores, MI 48081
Phone: (586) 552-8090 • Fax: (586) 772-2932

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? ________________

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 you 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

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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

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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
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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
☐ Alcohol		☐ Opiates/Heroin		☐ Steroids	
☐ Marijuana		☐ Sedatives		☐ Pain Killers	
☐ Cocaine		☐ Amphetamines		☐ Hallucinogens	
☐ Crack		☐ Inhalants		☐ Other	
☐ Ecstasy		☐ 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? ______________________________

____

____

____

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Current Symptom Checklist

Are you presently aware of having any of the following conditions? Check any that apply:

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