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

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:

(Check all that apply):

Race: ☐ Caucasian ☐ African-American ☐ 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? _____

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

Have you had problems following house rules? ☐ Yes ☐ No

Are there consequences set by your parents when you disobey house rules? ☐ Yes ☐ No

How do you feel about this? _____

Have you ever run away from home? ☐ Yes ☐ No

Do you have a curfew? ☐ Yes ☐ No

Do you have chores? ☐ Yes ☐ No If so what are they? _____

Is there anything you would like to see change at home that would make your life better? ☐ Yes ☐ No

_____

_____

_____

_____

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 (check one): ☐ A-B Student ☐ B-C Student ☐ C-D Student ☐ Failing

Have you ever been suspended from school? ☐ Yes ☐ No

Have you ever been expelled from school? ☐ Yes ☐ No

Have you ever repeated a grade? ☐ Yes ☐ No

Have you ever been enrolled in special education classes? ☐ Yes ☐ No

Do you have trouble concentrating, understanding, or remembering? ☐ Yes ☐ No

Do you like school? ☐ Yes ☐ No Why or why not? _____

What would make school better for you? _____

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Religious/Spiritual Background:

Do you believe in God or a Higher Power? ☐ Yes ☐ No

What is your religion? _____

Do you practice your religion ☐ Regularly ☐ Irregularly ☐ Never?

Work History:

Do you currently have a job? ☐ Yes ☐ No If so, where?_____

What do you do at work? _____

How many hours a week do you work? _____ Do you like your job? ☐ Yes ☐ No

Do you have any problems at work? _____

Social Background:

With whom do you spend MOST of your free time? Check 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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If so, what happened? _____

Do you ever feel like you do not belong? ☐ Yes ☐ No

Do you have trouble making or keeping friends? ☐ Yes ☐ No

Leisure Time/Interests:

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

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

☐ Regularly ☐ Sometimes ☐ Irregularly ☐ Rarely ☐ Never

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Has your 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

Have you had a physical exam in the last year? ☐ Yes ☐ No

Do you have any current physical problems, symptoms, or pain that you are not receiving medical attention for? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No

Is there ANY CHANCE that you may be pregnant? ☐ Yes ☐ No

If you are pregnant, are you receiving prenatal care? ☐ Yes ☐ No

List any medications that you are taking:

Type/Name/Dosage	Why do you take it?	Who prescribes this for you?

Has your eating or sleeping changed in the last year? ☐ Yes ☐ No How?_____

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

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 you ever been: ☐ Sexually Abused ☐ Physically Abused ☐ Emotionally Abused

By whom? _____

Age when abused: _____ Duration of Abuse: _____

Describe briefly what happened: _____

Do you feel suicidal now? ☐ Yes ☐ No Have you ever felt suicidal? ☐ Yes ☐ No

Do you feel you might hurt others? ☐ Yes ☐ No

Have you ever felt you might hurt others? ☐ Yes ☐ No

Have you ever attempted or had serious thoughts of suicide or hurting other people? ☐ Yes ☐ No

If so, when, and how? _____

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Sexual Background:

Are you sexually active? (Circle one) ☐ Yes ☐ No ☐ Sort Of ☐ Unsure

If so, do you use protection against pregnancy/sexually transmitted diseases? ☐ Yes ☐ No

Do you consider yourself to be:

☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Transgender ☐ Other ☐ Uncertain about your sexuality

Legal Status:

Do you have any legal problems now? ☐ Yes ☐ No

Have you ever had legal problems? ☐ Yes ☐ No

Have you ever been in a youth home? ☐ Yes ☐ No

Have you ever been arrested or ticketed? ☐ Yes ☐ No

What was the charge? _____

Are you currently:

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

Alcohol/Drug Use:

Do you smoke cigarettes? ☐ Yes ☐ No How much? _____

Are you allowed to smoke in the house? ☐ Yes ☐ No

Have you used ANY drugs or alcohol in the last 30 days that were not prescribed for you? ? ☐ Yes ☐ No

Have you ever used drugs by injection? ☐ Yes ☐ No If so, when? _____

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

Do you live with anyone who uses drugs/alcohol? ☐ Yes ☐ No

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

Additional Comments

Do you have any other comments? _____

_____

_____

_____

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Signature of Client _____ Date _____

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

Signature of Therapist _____ Date _____