Inner Guidance Counseling Center PLLC
Biopsychosocial Questionnaire—Adult

Name:_____ SSN:_____

Address:_____ City: _____ Zip _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Birth Date: _____ Age: _____ Sex: _____

Emergency Contact: _____ Phone: _____

Please indicate the primary reason for seeking therapy and what you hope to get out of therapy:

_____

_____

What strengths and abilities do you possess to help with therapy?_____

_____

_____

How will you know therapy is working and when therapy is completed?_____

_____

_____

Have you been in therapy for mental health in the past? ❑Yes ❑No

If "Yes", please explain: _____

_____

_____

FAMILY HISTORY:

Place of Birth: _____ # of Siblings: _____ Your Birth Order: _____

Provide information regarding deceased siblings (Cause of death, age at death, etc.): _____

_____

_____

Father's Education: _____ Occupation:_____ Age:____ Year, if deceased_____

Mother's Education:_____ Occupation:_____ Age:____ Year, if deceased_____

Stepparent History: _____

_____

With whom did you live while growing up? _____

Where did you grow up? _____

Describe your relationship with your:

Mother:_____

_____

_____

Father:_____

_____

_____

Brothers/Sisters:_____

_____

_____

_____

Have you ever been physically or sexually abused? ❑Yes ❑No

Have you ever physically or sexually abused someone? ❑Yes ❑No

Have your parents or any other family members had mental health, alcohol or any drug problems?

❑Yes ❑No If "Yes", please described and list treatments:_____

_____

_____

_____

ADULT/MARITAL HISTORY

Marital Status: ❑Single ❑Separated ❑Divorced ❑Widowed ❑Married ❑Cohabitate with partner

For each Marriage:

Date:	Age:	# of Children	# of Years	If no longer married: reason, date

List name and age of children (indicate if biological, step, or half): _____

_____

_____

Check the best description of your relationship with your spouse or significant other:

❑Excellent ❑Good ❑Fair ❑Poor

Please Explain: _____

_____

Who lives in your household? _____

_____

Family Relationships (Described home environment including relationship with children):_____

_____

_____

_____

EDUCATION

High grade completed: _____ Are you a: ❑High school Graduate or ❑GED

College Degrees or vocation certificates:_____

_____

Are you satisfied with your education? ❑Yes ❑No No If not, why?_____

_____

Are you currently employed? ❑Yes ❑No If yes, where?_____

Job Title:_____ Years: ___ Are you satisfied with your job? ❑Yes ❑No

Explain: _____

_____

Previous employment History:_____

_____

Military Service? ❑Yes ❑No Branch:_____ Years:____ Discharge Status:_____

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

_____

SOCIAL RELATIONSHIPS

Your friendships: ❑Close Friends ❑Only Acquaintances ❑Acquaintances & Friends

Number of close friends: ____ How often do you see them: ❑Daily ❑Frequently ❑Infrequently

LEISURE TIME

How do you spend 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 2 years? ❑Yes ❑No If "Yes", explain:_____

_____

FINANCES

Are you currently experiencing financial problems? ❑ Yes ❑No If "Yes, please explain: _____

_____

LEGAL PROBLEMS

Have you ever been involved with the police or courts? ❑Yes ❑No
If "Yes", please provide the following:

Charge	Date	Outcome

SPIRITUAL LIFE

Did you attend religious services with your family as a child? ❑Yes ❑No
Was religion a positive influence for 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 identify your cultural and ethnic background:_____

_____

MEDICAL STATUS

Date of most recent physical:_____ Any disability or handicap? ❑Yes ❑No If "Yes", please describe:_____

Have you been diagnosed with (Check all that apply):

	Heart Disease		Pituitary Gland Disorder		Diabetes
	Cancer		Pneumonia		Allergies
	Ulcers		Gastrointestinal Disorder		Thyroid Condition
	Asthma		High/Low Blood Pressure		Sexual Transmitted Disease
	Hypoglycemia		Pre-Menstrual Syndrome		Convulsions/Seizures
	Colitis		Tested Positive for HIV		Abnormal Menstruation
	Infertility		Miscarriages		Other

Please provide dates and explanations of any checked item:_____

_____

_____

Do you smoke cigarettes or use tobacco products? ❑Yes ❑No If "Yes", how much:_____

Do you drink caffeine products? ❑Yes ❑No If "Yes", what and how often:_____

Please list all medications (Prescription and Non-Prescription) you are currently taking:

Name	Dose	Frequency	Name	Dose	Frequency

ALCOHOL/DRUG USE

Do you currently drink alcohol? ❑Yes ❑No If "Yes", how often? _____

Age of first use? _____ Last time used? _____

Have you ever had a bad reaction (e.g. blackouts, shakes) from alcohol use? ❑Yes ❑No

If "Yes", please explain: _____

Do you currently use drugs? ❑Yes ❑No If "Yes", specify type and frequency:_____

_____

Age of first use? _____ Last time used? _____

Have you ever had a bad reaction (e.g. blackouts, overdose, shakes) to prescribed, over the counter or street drugs? ❑Yes ❑No If "Yes", please explain: _____

_____

EMOTIONAL/BEHAVIORAL FUNCTIONING

Check any symptoms you are experiencing:

	Anger Outbursts		Excessive Worry		Lack of Appetite		Poor School Attendance
	Anxiety		Extreme Mood Changes		Legal Problems		Rage/Aggression
	Argumentativeness		Fatigue		Low Motivation		Restlessness
	Crying Spells		Helplessness		Negative Self-Talk		Substance Abuse
	Decreased Energy		Hopelessness		Obsessive Behavior		Trouble Getting to Sleep
	Defiance		Impulsivity		Overeating		Trouble Staying Asleep
	Depressed Mood		Indecisiveness		Panic Attacks		Violation of Rules
	Excessive Guilt		Irritability		Poor Concentration		Waking Prematurely
	Excessive Sleep		Isolating Self		Poor Organization/Plan		Withholding Feelings

Suicidal/Homicidal 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

_____

Signature of Client Date

I have reviewed this form with the patient:_____

Clinician Signature Date