CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
and
ASSESSMENT FORM

CLIENT INFORMATION

Client Name (First) _____ (MI) ____ (Last) _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Phone No. (Home) (_____) _____ (Work) (_____) _____ (Cell) (_____) _____

Social Security Number _____ Sex: F ☐ M ☐ Age _____ Date of Birth _____/_____/_____

PARENT/GUARDIAN OR PARTNER
if different from client or parent/guardian of a minor child

Name (First) _____ (MI) ____ (Last) _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Phone No. (Home) (_____) _____ (Work) (_____) _____ (Cell) (_____) _____

Relationship: Spouse ☐ Parent/Legal Guardian ☐ DPHHS/DFS ☐ Other ☐ *specify:* _____

PHYSICIAN/MEDICAL PROVIDER

Name _____

Agency/Organization _____

Address _____ City _____ State _____ Zip _____

Office (_____) _____ Fax (_____) _____ Signed Released? ☐

PSYCHIATRIST
if applicable

Name _____

Agency/Organization _____

Address _____ City _____ State _____ Zip _____

Office (_____) _____ Fax (_____) _____ Signed Released? ☐

SCHOOL INFORMATION
if client is a minor child

Teacher/Staff Name _____ Grade _____

School _____

Address _____ City _____ State _____ Zip _____

Office (_____) _____ Fax (_____) _____ Signed Released? ☐

EMPLOYER
if applicable

Name _____

Agency/Organization _____

Address _____ City _____ State _____ Zip _____

Office (_____) _____ Fax (_____) _____ Signed Released? ☐

CASE MANAGER
if applicable

Name _____

Agency/Organization _____

Address _____ City _____ State _____ Zip _____

Office (_____) _____ Fax (_____) _____ Signed Released? ☐

REFERRAL SOURCE
if not previously identified above

Name _____

Agency/Organization _____

Address _____ City _____ State _____ Zip _____

Office (_____) _____ Fax (_____) _____ Signed Released? ☐

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE and ASSESSMENT FORM

PRESENTING PROBLEM

Please identify your primary concerns or symptoms:

_____

_____

Please rate the current intensity of symptoms for each of the following:

	None	Mild	Mod.	Severe
Learning Problems	☐	☐	☐	☐
Motor Skill Problems	☐	☐	☐	☐
Communication Deficits	☐	☐	☐	☐
Stuttering/Speech Impairment	☐	☐	☐	☐
Repeats Words of Others	☐	☐	☐	☐
Repetitive Behaviors	☐	☐	☐	☐
Poor Peer Relationships	☐	☐	☐	☐
Inattention	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Aggressive Behavior	☐	☐	☐	☐
Animal Cruelty	☐	☐	☐	☐
Property Destruction	☐	☐	☐	☐
Chronic Lying	☐	☐	☐	☐
Stealing	☐	☐	☐	☐
Conduct Problems	☐	☐	☐	☐
Easily Loses Temper	☐	☐	☐	☐
Oppositional Behavior	☐	☐	☐	☐
Eating Non-Food Items	☐	☐	☐	☐
Tics/Twitches	☐	☐	☐	☐
Encopresis (soiling self)	☐	☐	☐	☐
Enuresis (wetting self)	☐	☐	☐	☐
Immaturity	☐	☐	☐	☐
Inappropriate Sexual Behaviors	☐	☐	☐	☐
Not Trustworthy	☐	☐	☐	☐
Indiscriminate Sociability	☐	☐	☐	☐
Clinginess	☐	☐	☐	☐
Self Injurious Threats	☐	☐	☐	☐
Lack of Attachment	☐	☐	☐	☐
Distrustful	☐	☐	☐	☐
Memory Impairment	☐	☐	☐	☐
Disorientation	☐	☐	☐	☐
Cognitive Impairment (thinking)	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐
Alcohol Overuse/Abuse	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Paranoia	☐	☐	☐	☐
Poor Hygiene/Grooming	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Diminished Interest in Activities	☐	☐	☐	☐
Significant Weight Gain/Loss	☐	☐	☐	☐
Insomnia/Hypersomnia	☐	☐	☐	☐
Fatigue/Low Energy	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐
Agitation	☐	☐	☐	☐
Feelings of Worthlessness	☐	☐	☐	☐
Inappropriate Guilt	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Low Self-Esteem	☐	☐	☐	☐
Unresolved Grief	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐

	None	Mild	Mod.	Severe
Elevated Mood	☐	☐	☐	☐
Decreased Need for Sleep	☐	☐	☐	☐
Pressured Speech	☐	☐	☐	☐
Racing Thoughts	☐	☐	☐	☐
Distractibility	☐	☐	☐	☐
Excessive Goal-Directed Behaviors	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐
Excessive Anxiety/Worry	☐	☐	☐	☐
Avoidance of Situations	☐	☐	☐	☐
Phobia(s)	☐	☐	☐	☐
Obsessive Thoughts	☐	☐	☐	☐
Compulsive Behaviors	☐	☐	☐	☐
Exposure to a Trauma	☐	☐	☐	☐
Intrusive Memories	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐
Flashbacks	☐	☐	☐	☐
Hypervigilance	☐	☐	☐	☐
Loss of Time	☐	☐	☐	☐
Detachment from Others	☐	☐	☐	☐
Anger Outbursts	☐	☐	☐	☐
Exaggerated Startle Response	☐	☐	☐	☐
Restlessness	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐
Physical Disability	☐	☐	☐	☐
Several Physical Complaints	☐	☐	☐	☐
Impaired Sensory/Motor Function	☐	☐	☐	☐
Preoccupation with Appearance	☐	☐	☐	☐
Memory Problems	☐	☐	☐	☐
Depersonalization/Derealization	☐	☐	☐	☐
Dissociation	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐
Sexual Arousal Concerns/Addiction	☐	☐	☐	☐
Gender Confusion/Concerns	☐	☐	☐	☐
Laxative/Diuretic Abuse	☐	☐	☐	☐
Excessive Dieting	☐	☐	☐	☐
Excessive Exercise	☐	☐	☐	☐
Binging/Purging	☐	☐	☐	☐
Sleepwalking	☐	☐	☐	☐
Sleep Terrors	☐	☐	☐	☐
Fire-Setting/Fascination with Fire	☐	☐	☐	☐
Gambling	☐	☐	☐	☐
Pulling out Hair	☐	☐	☐	☐
Suspicious of Others	☐	☐	☐	☐
Social Discomfort/Isolation	☐	☐	☐	☐
Unstable Interpersonal Relationships	☐	☐	☐	☐
Self-Mutilation	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐
Sexual Promiscuity	☐	☐	☐	☐
Attention-Seeking Behaviors	☐	☐	☐	☐
Excessive Dependency on Others	☐	☐	☐	☐
Witness to Domestic Violence	☐	☐	☐	☐
Sexual Abuse Victim	☐	☐	☐	☐
Physical/Emotional Abuse Victim	☐	☐	☐	☐
Sexual Abuse Perpetrator	☐	☐	☐	☐
Physical/Emotional Abuse Perpetrator	☐	☐	☐	☐

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_____

2510 Continental Drive, Butte, MT 59701 • Office: 406.782.4778 • Fax: 406.782.1318 • www.compassprofessionalservices.com

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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FAMILY HISTORY

PARENTS

Mother's Name ________________________________ Biological Parent ☐ Adoptive Parent ☐
Living ☐ *if living, her age* ________ *if living, her location* ____________________ Deceased ☐ *if deceased, what year* ________
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried ☐ _____ *time(s)* Other ☐ ____________
Education Level: Some High School ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post-Graduate ☐
Occupation ____________________ General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Parent: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Parent: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐

Father's Name ________________________________ Biological Parent ☐ Adoptive Parent ☐
Living ☐ *if living, his age* ________ *if living, his location* ____________________ Deceased ☐ *if deceased, what year* ________
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried ☐ _____ *time(s)* Other ☐ ____________
Education Level: Some High School ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post-Graduate ☐
Occupation ____________________ General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Parent: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Parent: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐

Stepmother's Name ________________________________
Living ☐ *if living, her age* ________ *if living, her location* ____________________ Deceased ☐ *if deceased, what year* ________
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried ☐ _____ *time(s)* Other ☐ ____________
Education Level: Some High School ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post-Graduate ☐
Occupation ____________________ General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Parent: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Parent: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐

Stepfather's Name ________________________________
Living ☐ *if living, his age* ________ *if living, his location* ____________________ Deceased ☐ *if deceased, what year* ________
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried ☐ _____ *time(s)* Other ☐ ____________
Education Level: Some High School ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post-Graduate ☐
Occupation ____________________ General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Parent: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Parent: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐

How often do/did parents argue or fight? Rarely ☐ Occasionally ☐ Frequently ☐ Not Applicable ☐
How do/did parents work out their differences with each other? Talk ☐ Shout ☐ Silence☐ Left the house ☐ Other ☐ *(explain)*____________

SIBLINGS ☐ N/A – client has no siblings

Sibling Name ________________________________
Sex: F ☐ M ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling ☐
Living ☐ *if living, age* ________ *if living, location* ____________ Deceased ☐ *if deceased, what year* ________
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Sibling: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ________________________________ Age __________
Children's Names: ________________________________

Sibling Name ________________________________
Sex: F ☐ M ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling ☐
Living ☐ *if living, age* ________ *if living, location* ____________ Deceased ☐ *if deceased, what year* ________
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Sibling: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ________________________________ Age __________
Children's Names: ________________________________

Sibling Name ________________________________
Sex: F ☐ M ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling ☐
Living ☐ *if living, age* ________ *if living, location* ____________ Deceased ☐ *if deceased, what year* ________
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Sibling: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ________________________________ Age __________
Children's Names: ________________________________

Sibling Name ________________________________
Sex: F ☐ M ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling ☐
Living ☐ *if living, age* ________ *if living, location* ____________ Deceased ☐ *if deceased, what year* ________
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Sibling: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ________________________________ Age __________
Children's Names: ________________________________

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Sibling Name ____
Sex: F ☐ M ☐ Full Sibling ☐ Half Sibling ☐ Step Sibling ☐
Living ☐ *if living, age* ________ *if living, location* ________________ Deceased ☐ *if deceased, what year* ________
Presence During Childhood: Entire ☐ Part ☐ None ☐
Current Relationship with Sibling: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ______________________________________ Age __________
Children's Names: ______________________________________

MARITAL STATUS

Current Marital Status: Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Involved ☐ Other ☐ ____________________
How long has this been your current marital status? ________ months/years Number of Prior Marriages 0 ☐ 1☐ 2 ☐ 3 ☐ 3+ ☐
Relationship Satisfaction: Very Satisfied ☐ Satisfied ☐ Somewhat Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐ N/A ☐

PARTNER ☐ N/A – client is not involved

Current Partner's Name ______________________________________ Age __________
Number of Prior Marriages 0 ☐ 1☐ 2 ☐ 3 ☐ 3+ ☐
Current Relationship with Partner: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Partner: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐

Former Partner's Name ______________________________________ Age __________
Number of Prior Marriages 0 ☐ 1☐ 2 ☐ 3 ☐ 3+ ☐
Living ☐ *if living, age* ________ *if living, location* ________________ Deceased ☐ *if deceased, what year* ________
Current Relationship: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐

Former Partner's Name ______________________________________ Age __________
Number of Prior Marriages 0 ☐ 1☐ 2 ☐ 3 ☐ 3+ ☐
Living ☐ *if living, age* ________ *if living, location* ________________ Deceased ☐ *if deceased, what year* ________
Current Relationship: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐

CHILDREN ☐ N/A – client has no children

Child's Name ____
Sex: F ☐ M ☐ Biological Child ☐ Adopted Child ☐ Step Child ☐
Living ☐ *if living, age* ________ *if living, location* ________________ Deceased ☐ *if deceased, what year* ________
Current Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ______________________________________ Age __________
Children's Names: ______________________________________

Child's Name ____
Sex: F ☐ M ☐ Biological Child ☐ Adopted Child ☐ Step Child ☐
Living ☐ *if living, age* ________ *if living, location* ________________ Deceased ☐ *if deceased, what year* ________
Current Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ______________________________________ Age __________
Children's Names: ______________________________________

Child's Name ____
Sex: F ☐ M ☐ Biological Child ☐ Adopted Child ☐ Step Child ☐
Living ☐ *if living, age* ________ *if living, location* ________________ Deceased ☐ *if deceased, what year* ________
Current Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ______________________________________ Age __________
Children's Names: ______________________________________

Child's Name ____
Sex: F ☐ M ☐ Biological Child ☐ Adopted Child ☐ Step Child ☐
Living ☐ *if living, age* ________ *if living, location* ________________ Deceased ☐ *if deceased, what year* ________
Current Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ______________________________________ Age __________
Children's Names: ______________________________________

Child's Name ____
Sex: F ☐ M ☐ Biological Child ☐ Adopted Child ☐ Step Child ☐
Living ☐ *if living, age* ________ *if living, location* ________________ Deceased ☐ *if deceased, what year* ________
Current Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Previous Relationship with Child: Positive ☐ Neutral ☐ Negative ☐ Abusive ☐ Absent ☐
Partner's Name: ______________________________________ Age __________
Children's Names: ______________________________________

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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CHILDHOOD EXPERIENCES

Birthplace _____ Childhood Home(s) _____

Frequent Moves? No ☐ Yes ☐ Were you ever in foster care? No ☐ Yes ☐ I*f yes, at what age?* _____ *and for what length of time?* _____

How would you describe the discipline used in your home? Strict ☐ Moderate ☐ Permissive ☐ Inconsistent ☐ Other ☐ _____

How do/would you describe your childhood family experience? Outstanding ☐ Normal ☐ Chaotic ☐ Witness to Abuse ☐ Victim of Abuse ☐

Are/Were there frequent family arguments? No ☐ Yes ☐

Are/Were there major financial problems? No ☐ Yes ☐

Are/Were there any traumatic events? No ☐ Yes ☐ *If yes, explain:* _____

Are/Were there any significant deaths (people/favorite pet)? No ☐ Yes ☐ *If yes, explain:* _____

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CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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DEVELOPMENTAL HISTORY

PREGNANCY/DELIVERY

Was the pregnancy normal? No ☐ Yes ☐
Was the pregnancy full-term? No ☐ Yes ☐ *if no, how premature was the delivery?* _____ *weeks premature*
Birth Weight _____lbs. _____oz.

Pregnancy Complication(s) *(check all that apply)*:

☐ None ☐ Drug Use ☐ Kidney Infection
☐ Alcohol Use ☐ Emotional Stress ☐ Psychiatric Impairment
☐ Bleeding ☐ Gestational Diabetes ☐ Tobacco Use
☐ Domestic Violence ☐ High Blood Pressure ☐ Other *explain*_____

Birth Complication(s) *(check all that apply)*:

☐ None ☐ Induction ☐ Other *explain* _____
☐ Caesarean Delivery ☐ Multiple Birth
☐ Difficult Delivery ☐ Prolonged Labor

CHILDHOOD HEALTH

How would you describe your/the client's childhood health?

☐ Normal ☐ Ear Infections ☐ Tubes in Ears
☐ Developmental Delay ☐ Head Injury ☐ Other *explain*_____

Chronic/Serious Health Problem(s) No ☐ Yes ☐ *If yes, explain:* _____
Significant/Unusual Illness(es) No ☐ Yes ☐ I*f yes, explain:* _____
Significant Injury(s) No ☐ Yes ☐ I*f yes, explain:* _____
Hospitalization(s) No ☐ Yes ☐ I*f yes, explain:* _____
Surgery(s) No ☐ Yes ☐ I*f yes, explain:* _____

DEVELOPMENT

Infancy Problems:

☐ None ☐ Sleeping Problems ☐ Difficult to Soothe
☐ Feeding Problems ☐ Toilet-Training Problems ☐ Other *explain*_____

Delayed Milestones:

☐ None ☐ Speaking Words ☐ Tolerating Separation
☐ Head Control ☐ Speaking Sentences ☐ Playing Cooperatively
☐ Rolling Over ☐ Bladder Control ☐ Riding Tricycle
☐ Sitting ☐ Bowel Control ☐ Riding Bicycle
☐ Standing ☐ Sleeping Alone ☐ Other *explain*_____
☐ Walking ☐ Dressing Self
☐ Feeding Self ☐ Engaging Peers

OTHER INFORMATION

Were you/the client placed in child care during infancy? No ☐ Yes ☐ *If yes, what kind?*

☐ Full-time ☐ Overnight ☐ Other *explain*_____
☐ Part-time ☐ More than a day at time

Were there periods of separation from primary caregiver? No ☐ Yes ☐ I*f yes, why?*

☐ Child's Hospitalization ☐ Parent Mental Health Problems ☐ Partner Separation
☐ Parent Incarceration ☐ Parent Substance Abuse ☐ Other *explain* _____

Were you//the client ever a childhood victim of physical abuse? No ☐ Yes ☐
Were you//the client ever a childhood victim of sexual abuse? No ☐ Yes ☐

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CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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SUBSTANCE ABUSE HISTORY

PERSONAL USE HISTORY

Substances Used	Age/First Use	Age/ Last Use	Average Amount	Frequency	Current Use
☐ Alcohol	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Amphetamines/Speed	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Barbiturates/Downers	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Cocaine	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Crack Cocaine	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Hallucinogens (i.e., LSD)	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Inhalants (i.e., Glue, Gas)	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Marijuana	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Methamphetamines	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Nicotine/Cigarettes	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ PCP	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Prescription	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐
☐ Other	_____	_____	_____ per	Day ☐ Week ☐ Month ☐	No ☐ Yes ☐

Children & Adolescents Only ☐ N/A – client is an adult

1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? No ☐ Yes ☐
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? No ☐ Yes ☐
3. Do you ever use alcohol or drugs while you are by yourself, alone? No ☐ Yes ☐
4. Do you ever forget things you did while using alcohol or drugs? No ☐ Yes ☐
5. Does your family or friends ever tell you that you should cut down on your drinking or drug use? No ☐ Yes ☐
6. Have you ever gotten into trouble while you were using alcohol or drugs? No ☐ Yes ☐

Adults Only ☐ N/A – client is an adolescent/child

1. Have you ever felt you should cut down on your drinking/drug use? No ☐ Yes ☐
2. Have people annoyed you by criticizing your drinking/drug use? No ☐ Yes ☐
3. Have you ever felt bad or guilty about your drinking/drug use? No ☐ Yes ☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? No ☐ Yes ☐

CONSEQUENCES OF SUBSTANCE USE *(check all that apply)*

- ☐ Assaultive Behavior
- ☐ Blackouts
- ☐ Educational Problems
- ☐ Employment Problems
- ☐ Hangovers
- ☐ Hazardous Behaviors
- ☐ Interpersonal/Social Problems
- ☐ Legal Problems/Arrests
- ☐ Medical Problems
- ☐ Overdose
- ☐ Parental Neglect
- ☐ Sleep Disturbance
- ☐ Suicidal Ideation
- ☐ Tolerance Symptoms
- ☐ Withdrawal Symptoms
- ☐ Other _____

TREATMENT HISTORY

Have you ever received treatment for substance abuse/dependence? No ☐ Yes ☐ I*f yes, which have you received? (check all that apply)*

☐ Outpatient Treatment _____ (Treatment Facility/Provider) _____ (Year) _____ (Length of Treatment) Helpful? No ☐ Yes ☐

☐ Inpatient Treatment _____ (Treatment Facility/Provider) _____ (Year) _____ (Length of Treatment) Helpful? No ☐ Yes ☐

☐ 12-Step program _____ (Treatment Facility/Provider) _____ (Year) _____ (Length of Treatment) Helpful? No ☐ Yes ☐

☐ Stopped on Own ☐ Other *explain* _____

FAMILY SUBSTANCE USE HISTORY

Is there a family history of substance abuse/dependence? No ☐ Yes ☐ I*f yes, who?*

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Drug of Choice) Active: No ☐ Yes ☐

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Drug of Choice) Active: No ☐ Yes ☐

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Drug of Choice) Active: No ☐ Yes ☐

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Drug of Choice) Active: No ☐ Yes ☐

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Drug of Choice) Active: No ☐ Yes ☐

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CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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SOCIO-ECONOMIC

CURRENT LIVING SITUATION

How would you describe your/the client's current living situation? *(check all that apply)*

☐ Foster Home ☐ Living Independently ☐ Supported Independent Living
☐ Group Home ☐ Living Independently with others ☐ Therapeutic Foster Care
☐ Homeless ☐ Living with Others In their Care ☐ Other *explain*_____
☐ Hospitalization ☐ Nursing Home
☐ Jail ☐ Shelter/Mission

Are there any housing issues that contribute to your/the client's current problem? No ☐ Yes ☐ *If yes, check all that apply:*

☐ Dependent on Others for Housing ☐ Housing Dangerous/Deteriorating ☐ Living Companions Dysfunctional
☐ Homeless ☐ Housing Overcrowded ☐ Other *explain*_____

Who currently lives in the household? _____

SEXUAL HISTORY

Have you/the client ever been raped, molested, or sexually abused? No ☐ Yes ☐ *If yes, please answer the following:*

Name of Perpetrator: _____ Prosecuted? No ☐ Yes ☐

Relationship with Perpetrator:

☐ Acquaintance ☐ Friend ☐ Spouse
☐ Boy/Girlfriend ☐ Parent ☐ Stranger
☐ Coworker ☐ Professional ☐ Other *explain*_____
☐ Extended Relative ☐ Sibling

Do you/the client have a history of sexual reactivity? No ☐ Yes ☐

Adolescents and Adults Only ☐ N/A – client is a child

What is your/the client's sexual orientation? Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgendered ☐
Are you/the client currently sexually active? No ☐ Yes ☐
If yes, are you/the client sexually satisfied? No ☐ Yes ☐
Do you/the client have a history of sexual promiscuity? No ☐ Yes ☐
Do you/the client have a history of having unprotected sex? No ☐ Yes ☐
Have you/the client ever tested positive for HIV/AIDS or another sexually transmitted disease? No ☐ Yes ☐
What was your/the client's age at the time of your first sexual experience? _____
What was your/the client's age at the time of your first pregnancy/fatherhood? _____

CULTURAL HISTORY

What is your/the client's race/ethnicity? *(check all that apply)*

☐ White/Caucasian ☐ Black/African American ☐ Other *explain* _____
☐ American Indian/Alaskan ☐ Hispanic/Latino
☐ Asian ☐ Native Hawaiian/Pacific Islander

What is your/the client's cultural identity? _____
Do you/the client celebrate/practice any particular cultural/ethnic traditions (i.e., smudging, foods, special holidays)? No ☐ Yes ☐
If yes, explain: _____
Are there any cultural issues that contribute to your/the client's current problem(s)? No ☐ Yes ☐
If yes, explain: _____

SPIRITUAL HISTORY

What is your/the client's spiritual/religious identity? _____
Do you/the client currently participate in any spiritual/religious activities? No ☐ Yes ☐
If yes, explain: _____
Are there any spiritual/religious issues that contribute to your/the client's current problem(s)? No ☐ Yes ☐
If yes, explain: _____

RECREATIONAL ACTIVITIES

Are you/the client currently active in any community/recreational activities? No ☐ Yes ☐
If yes, explain: _____
If *no, were you/the client formerly active in community/recreational activities?* No ☐ Yes ☐
What recreational activities and hobbies do you/the client participate? _____

SOCIAL SUPPORT NETWORK

How would you describe your/the client's social support?

☐ Distant from Family ☐ No Friends ☐ Supportive
☐ Few Friends ☐ Substance-Using Friends ☐ Other *explain*_____

Do you/the client have the support of community members (i.e., coaches, club leaders, case managers)? No ☐ Yes ☐
If yes, please name them: _____

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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Do you/the client receive support/involvement from any of the following agencies? No ☐ Yes ☐ *If yes, check all that apply:*

☐ Adult Probation	☐ Head Start/Early Head Start	☐ Pre-Release
☐ AWARE	☐ Health Department	☐ Primary Health Care
☐ Big Brothers/Big Sisters	☐ Housing Agency	☐ Safe Space
☐ Butte Sheltered Workshop	☐ Human Resource Council	☐ Salvation Army
☐ Career Futures	☐ Juvenile Probation	☐ Sylvan Learning Center
☐ Department of Family Services	☐ NAMI	☐ Vocational Rehabilitation
☐ Developmental Disabilities	☐ None	☐ Western Montana Mental Health
☐ Family Outreach	☐ North American Indian Alliance	☐ Youth Dynamics Inc.
☐ Four Cs	☐ PLUK	☐ Other _____

MILITARY HISTORY

Adults Only ☐ N/A – client is an adolescent/child

What is your/the client's military history? Never in Military ☐ Served in Military ☐

If so, are you/the client: Active ☐ Reservist ☐ Honorably Discharged ☐ Dishonorably Discharged ☐

FINANCIAL STATUS & STRESSES

How would you describe your/the family's current financial status and/or stressors? *(check all that apply)*

☐ No Current Financial Problems	☐ Impulsive Spending	☐ Poverty or Below-Poverty Income
☐ Conflicts about Finances	☐ Large Indebtedness	☐ Other *explain*_____
☐ Filing for Bankruptcy	☐ Poor Credit History	

Do you/the client have health insurance? No ☐ Yes ☐

Do you/the client receive any of the following *(check all that apply)*? Medicaid ☐ TANF ☐ Medicare ☐ SSI ☐ SSDI ☐

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CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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LEGAL HISTORY

TREATMENT

Are you pursuing treatment voluntary? No ☐ Yes ☐ *If no, check the following that applies:*

☐ Voluntary
☐ Involuntary – Mandated by DPHHS/DFS treatment plan.
☐ Involuntary – Civil *(Person committed for treatment through a civil court process.)*
☐ Involuntary – Criminal *(Person required to receive treatment or evaluation by a criminal court proceeding.)*

CUSTODY STATUS OF CHILD

☐ Parents/Guardians Custody _____
Name of Parent(s) with Medical/Resident/Full Custody

☐ DPHHS/DFS Custody_____
Name of DPHHS/DFS Worker

LEGAL HISTORY

How would you describe your/the client's legal history *(check all that apply)*?

☐ No Legal Problems
☐ Currently on Parole/Probation
☐ Misdemeanors #: _____
  ☐ Non-Substance-Related Crimes (*describe the charges)* _____
  ☐ Substance-Related Crimes (*describe the charges)* _____
☐ Felonies #: _____
  ☐ Non-Substance-Related Crimes (*describe the charges)* _____
  ☐ Substance-Related Crimes (*describe the charges)* _____

Have you/the client ever been incarcerated? No ☐ Yes ☐ *If yes, complete the following that applies:*

☐ Jail *Number of Times:* _____ *Total Time Served:* _____*days/weeks/months/years*
☐ Prison *Number of Times:* _____ *Total Time Served:* _____*days/weeks/months/years*
☐ Pre-Release *Number of Times:* _____ *Total Time Served:* _____*days/weeks/months/years*
☐ Other *Number of Times:* _____ *Total Time Served:* _____*days/weeks/months/years*

PROBATION/PAROLE STATUS

☐ Informal Juvenile Probation_____ Sentence Time Frame:_____/_____ to _____/_____
Probation Officer

☐ Formal Juvenile Probation _____Sentence Time Frame:_____/_____ to _____/_____
Probation Officer

☐ Adult Probation_____Sentence Time Frame:_____/_____ to _____/_____
Probation Officer

☐ Adult Parole_____ Sentence Time Frame:_____/_____ to _____/_____
Parole Officer

OTHER INFORMATION

Are you involved in any lawsuit or another legal matter? No ☐ Yes ☐

If yes, explain the legal matter: _____

If yes, who is your/the client's attorney? _____

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_____

_____

_____

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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EDUCATIONAL HISTORY

EDUCATIONAL STATUS

What is your/the client's current educational status?

☐ No Formal Educational Activity
☐ Home Schooled
☐ Preschool
☐ Elementary School
☐ Middle School/Junior High
☐ High School
☐ Adult Education Class/GED
☐ Vocational/Technical School
☐ College
☐ Graduate School
☐ Other *explain* _____

Current Grade in School:

☐ Pre-K
☐ Kindergarten
☐ 1st
☐ 2nd
☐ 3rd
☐ 4th
☐ 5th
☐ 6th
☐ 7th
☐ 8th
☐ 9th/Freshman
☐ 10th/Sophomore
☐ 11th/Junior
☐ 12th/Senior
☐ College Freshman
☐ College Sophomore
☐ College Junior
☐ College Senior
☐ Graduate Student
☐ N/A

What school do you/the client attend? _____

LEARNING DISABILITIES

Do you/the client have any learning disabilities? No ☐ Yes ☐ *If yes, what kind of learning disabilities do you/the child have? (check all that apply)*

☐ Comprehension Problems
☐ Math Problems
☐ Oral Language Problems
☐ Reading Problems
☐ Speech Problems
☐ Writing Problems
☐ Other *explain* _____

Is there a family history for learning disabilities? No ☐ Yes ☐ *If yes, who and what kind of learning disabilities are they?*

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Learning Disability)

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Learning Disability)

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Learning Disability)

_____ (Family Member) *Maternal* ☐ *Paternal* ☐ _____ (Learning Disability)

Have you/the client had an IQ test (i.e.., WISC, WAIS)? No ☐ Yes ☐ *If yes, what were the results?*

VIQ = _____ PIQ = _____ FIQ = _____

Do you/the client have an Individualized Education Plan (IEP)? No ☐ Yes ☐ Do you/the client have a 504 Plan? No ☐ Yes ☐

If yes, what special needs are being accommodated with the IEP? *(check all that apply)*

☐ ADHD
☐ Autism/Asperger's
☐ Developmental Delay
☐ Emotional Disorders
☐ Hearing Impairment
☐ Learning Disabilities
☐ Mental Retardation
☐ Speech/Language Impairment
☐ Visual Impairment
☐ Other *explain* _____

If yes, what kind of services/accommodations is received? *(check all that apply)*

☐ Additional Time
☐ Assistive Technology
☐ Audiology
☐ Counseling
☐ Medical Services/Nursing
☐ Modified Grades/Assignments
☐ Occupational Therapy
☐ Oral Exams
☐ Physical Therapy
☐ Preferred Seating
☐ Self-Contained Classroom
☐ Special Needs Para-Educator
☐ Speech Therapy
☐ Vision/Hearing Therapy
☐ Other *explain* _____

ACADEMIC FUNCTIONING

How would you describe your/the client's academic functioning?

☐ Normal Intelligence
☐ High Intelligence
☐ Learning Problems
☐ Mild Retardation
☐ Moderate Retardation
☐ Severe Retardation

What kind of grades do you/the client receive?

☐ All As
☐ As & Bs
☐ Bs & Cs
☐ Cs & Ds
☐ Ds & Fs
☐ All Fs

What was your/the client's most recent grade point average (GPA)? *If applicable* _____._____ GPA

SUBJECT INFORMATION

What subject is your/the client's favorite subject?

☐ English
☐ Math
☐ PE/Health
☐ Reading
☐ Science
☐ Social Studies

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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What subject is your/the client's least favorite subject?

☐ English ☐ PE/Health ☐ Science
☐ Math ☐ Reading ☐ Social Studies

What subject is your/the client's easiest subject?

☐ English ☐ PE/Health ☐ Science
☐ Math ☐ Reading ☐ Social Studies

What subject is your/the client's most difficult subject?

☐ English ☐ PE/Health ☐ Science
☐ Math ☐ Reading ☐ Social Studies

SOCIAL INTERACTION

How would you describe your/the client's social interaction? *(check all that apply)*

☐ Normal Social Interaction ☐ Bullies Others ☐ Very Shy
☐ Alienates Self ☐ Dominates Others ☐ Other *explain*_____
☐ Associates with Acting-Out Peers ☐ Isolates Self

RESPONSE TO AUTHORITY

Do you/the client experience problems in school due to behavioral problems? No ☐ Yes ☐
Have you/the client received disciplinarian action at school? No ☐ Yes ☐ *If yes, complete the information below:*

What behavior(s) has resulted in disciplinarian action? *(check all that apply)*

☐ Assaultive Behavior ☐ Insubordination/Defiance ☐ Threatening Behavior
☐ Disruptive Behavior ☐ Lack of Preparedness ☐ Unexcused Absences
☐ Excessive Absences ☐ Possession of Substances ☐ Other *explain* _____
☐ Excessive Tardiness ☐ Possession of Weapon
☐ Inappropriate Dress ☐ Profanity/Verbal Abuse

What disciplinarian actions have you/the client received? *(check all that apply)*

☐ Detention ☐ Office Referral ☐ Suspension (In-School)
☐ Discipline/"Pink" Slips ☐ Parent/Guardian Contact ☐ Suspension (Out-of-School)
☐ Expulsion ☐ School Meeting ☐ Other *explain* _____
☐ Legal Charges/Arrest ☐ SRO Contact

OTHER EDUCATIONAL INFORMATION

Describe your/the client's attention span: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Describe your/the client's activity level: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Describe your/the client's ability to follow directions: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Describe your/the client's handwriting: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Describe your/the client's ability to remain seated: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Describe your/the client's ability to organize tasks, time, & assignments: Excellent ☐ Good ☐ Fair ☐ Poor ☐

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CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE and ASSESSMENT FORM

EMPLOYMENT STATUS & HISTORY

CURRENT EMPLOYMENT INFORMATION

What is your/the client's current employment status? *(check all that apply)*

☐ Full time
☐ Part Time
☐ Self-Employed
☐ Unemployed
☐ Student
☐ Homemaker
☐ Retired
☐ Disabled/Unable to Work
☐ Supported/Sheltered
☐ Other *explain* _____

What are your/the client's employment concerns? *(check all that apply)*

☐ No Employment Concerns
☐ Conflicts with Coworkers
☐ Conflicts with Supervisor
☐ Dissatisfaction with Benefits
☐ Dissatisfaction with Compensation
☐ Dissatisfaction with Job (General)
☐ Dissatisfaction with Schedule
☐ Job Security
☐ Seasonal Work
☐ Unstable Work History
☐ Other *explain* _____

Are you/the client currently employed? No ☐ Yes ☐ *If yes, complete the information below:*
Current Employer:_____
Job Title/Position: _____ Time there :_____ months/years

PREVIOUS EMPLOYMENT INFORMATION

Former Employer:_____
Job Title/Position: _____ From_____/_____ To _____/_____
Reason for Leaving: _____

Former Employer:_____
Job Title/Position: _____ From_____/_____ To _____/_____
Reason for Leaving: _____

Former Employer:_____
Job Title/Position: _____ From_____/_____ To _____/_____
Reason for Leaving: _____

Former Employer:_____
Job Title/Position: _____ From_____/_____ To _____/_____
Reason for Leaving: _____

What job was the most important? _____
What job have you/the client enjoyed the most? _____
What job did you/the client have the longest tenure? _____

FUTURE EMPLOYMENT

What occupational goals do you/the client have for the future? _____
What actions have you/the client taken to pursue that goal? _____

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_____

_____

_____

Compass PROFESSIONAL SERVICES LLC

PSYCHIATRIC

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE and ASSESSMENT FORM

TREATMENT INFORMATION & HISTORY

Have you/the client ever received mental health treatment before? No ☐ Yes ☐ *If yes, complete the following. Please also include current treatment.*

	Treatment Facility/Provider	Year	Length of Treatment	Beneficial?
☐ Acute Treatment				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Biofeedback				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Case Management				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Counseling/Psychotherapy				No ☐ Yes ☐
				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Crisis Intervention				No ☐ Yes ☐
				No ☐ Yes ☐
☐ CSCT/School Based Mental Health Services				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Day Treatment				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Family Support Services				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Inpatient Treatment/ Residential Treatment				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Partial Hospitalization				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Psychiatric Care/ Medication Management				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Psychological Testing				No ☐ Yes ☐
				No ☐ Yes ☐
☐ Therapeutic Group Home/ Therapeutic Foster Care				No ☐ Yes ☐
				No ☐ Yes ☐

☐ Other *explain* _____

Which of the above noted treatment are you currently continuing to receive? _____

_____

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
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If you/the client have ever participated in counseling/psychotherapy before, please indicate what types you/the client have received: (check all that apply)

☐ Individual Therapy
☐ Couples Therapy
☐ Family Therapy
☐ Group Therapy
☐ Attachment Therapy
☐ Cognitive-Behavioral Therapy
☐ Dialectical Behavior Therapy
☐ Psychoeducational Therapy
☐ Solution-Oriented Brief Therapy
☐ Other *explain* _____

Overall, how would you rate your/the client's experience with and/or your/the client's perception of counseling/psychotherapy?
Excellent ☐ Good ☐ Fair ☐ Poor ☐

What reasons have you/the client terminated mental health treatment in the past?

☐ Treatment Goals Completed
☐ Conflict with a Provider
☐ Cost/Financial Barriers
☐ Negative Side Effects
☐ Time/Scheduling Constraints
☐ Treatment Goals Not Completed
☐ Went to a Higher Level of Care
☐ Went to a Lower Level of Care
☐ Other *explain* _____

What diagnoses (or from which category of disorders) have you/the client previously been diagnosed or for which you/client have been treated?

☐ No Past Diagnosis
☐ Unknown/Unsure
☐ ADHD/ADD
☐ Adjustment Disorder
☐ Asperger's
☐ Autism
☐ Bipolar Disorder
☐ Dementia/Delirium
☐ Depression
☐ Dissociative Disorder
☐ Dysthymic Disorder
☐ Eating Disorder
☐ Generalized Anxiety Disorder
☐ Obsessive Compulsive Disorder
☐ Oppositional Defiant Disorder
☐ Panic Disorder
☐ Personality Disorder
☐ PTSD
☐ Reactive Attachment Disorder
☐ Schizophrenia
☐ Sexual Disorder
☐ Sleep Disorder
☐ Other *explain* _____

Have you/the client ever experienced suicidal and/or homicidal thoughts? No ☐ Yes ☐ I*f yes, please explain:*
_____

Have you/the client ever been prescribed medication for psychological symptoms? No ☐ Yes ☐ I*f yes, complete the following:*
Indicate the medications you/the client are currently taking by checking the box prior to the medication name(s) you list below.

	Medication Name	Dosage & Frequency	Prescribed For	Time Began	Length Used	Beneficial?
☐				/_____		No ☐ Yes ☐
☐				/_____		No ☐ Yes ☐
☐				/_____		No ☐ Yes ☐
☐				/_____		No ☐ Yes ☐
☐				/_____		No ☐ Yes ☐
☐				/_____		No ☐ Yes ☐

FAMILY PSYCHIATRIC HISTORY

Is there a family history of mental health problems and/or psychiatric illness? No ☐ Yes ☐ I*f yes, complete the information below:*

	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
ADHD/ADD	☐	☐	☐	☐	☐	☐
Adjustment Disorder	☐	☐	☐	☐	☐	☐
Asperger's	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Dementia/Delirium	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Dissociative Disorder	☐	☐	☐	☐	☐	☐
Dysthymic Disorder	☐	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐
Generalized Anxiety Disorder	☐	☐	☐	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐	☐	☐	☐
Oppositional Defiant Disorder	☐	☐	☐	☐	☐	☐
Panic Disorder	☐	☐	☐	☐	☐	☐
Personality Disorder	☐	☐	☐	☐	☐	☐
PTSD	☐	☐	☐	☐	☐	☐
Reactive Attachment Disorder	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
Sexual Disorder	☐	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐	☐
Other *explain* _____	☐	☐	☐	☐	☐	☐

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CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE and ASSESSMENT FORM

MEDICAL

GENERAL HEALTH

Overall, how would you describe your current health? Excellent ☐ Good ☐ Fair ☐ Poor ☐
What is your current height? _____' _____" What is your current weight? _____ lbs.
Who is your/the client's primary medical provider? _____
Do you have any allergies to food or medications? No ☐ Yes ☐ If *yes, explain* _____

MEDICAL HISTORY

Have you/the client received a thorough medical exam within the past year? No ☐ Yes ☐ If *yes, please complete the following information:*
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

Have you/the client received a dental exam within the past year? No ☐ Yes ☐ If *yes, please complete the following information:*
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

Have you the client received a vision exam within the past year? No ☐ Yes ☐ If *yes, please complete the following information:*
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

Have you/the client ever been evaluated any of the following providers? No ☐ Yes ☐ If *yes, please complete the following information:*

☐ Neurologist
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

☐ Audiologist
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

☐ Dietician
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

☐ Occupational or Physical Therapist
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

☐ Speech/Language Pathologist
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

☐ Other Specialist _____
Provider: _____ Month/Year of Exam: _____/_____
Findings: Normal ☐ Abormal ☐ *If abnormal, explain* _____

MEDICAL SYMPTOMS/PROBLEMS

Do you have/have you had any of the following medical problems or symptoms?

☐ None
☐ Allergies
☐ Alzheimer's Disease/Dementia
☐ Anemia/Blood Disorder
☐ Asthma
☐ Autoimmune Disorder
☐ Backaches (frequent)
☐ Birth Defects
☐ Bleeding Problems
☐ Breathing Problems
☐ Cancer/Tumor
☐ Chest Pains
☐ Chronic Pain
☐ Constipation (frequent)
☐ Diabetes
☐ Diarrhea (frequent)
☐ Digestive Problems
☐ Dizziness
☐ Ear Infections (frequent)
☐ Fainting
☐ Fatigue (frequent)
☐ Fibromyalgia
☐ Glaucoma
☐ Head Injury
☐ Headaches (frequent)
☐ Hearing Problems
☐ Heart Disease/Problems
☐ Hepatitis
☐ High Blood Pressure
☐ Hyperglycemia/ Hypoglycemia
☐ Incontinence
☐ Infections/Colds/Flu (frequent)
☐ Kidney Problems
☐ Low Energy (frequent)
☐ Low Blood Pressure
☐ Migraine Headaches
☐ Narcolepsy
☐ Nosebleeds
☐ Overeating
☐ Overweight/Obesity
☐ Poor Coordination/Balance
☐ Radiation Therapy
☐ Reproductive Problems
☐ Rheumatic Fever
☐ Ringing in the Ears
☐ Seizures/Convulsions
☐ Sinus Problems
☐ Skin Problems
☐ Sleep Apnea
☐ Stomach Aches (frequent)
☐ Stroke
☐ Thirst (excessive)
☐ Thyroid Problems
☐ Toothaches
☐ Tuberculosis
☐ Unconsciousness
☐ Undereating
☐ Underweight
☐ Venereal Disease
☐ Visual Problems
☐ Weight Gain/Loss (rapid)
☐ Other *explain* _____

Have you had any serious accidents, surgeries, and/or hospitalizations in the last five years? No ☐ Yes ☐ If *yes, explain:*
_____

CLIENT BIOPSYCHOSOCIAL QUESTIONNAIRE
and
ASSESSMENT FORM

FEMALES ONLY ☐ N/A – client is a male

Are you pregnant? No ☐ Yes ☐ I*f so, how far along is the pregnancy?* _____ *weeks/progress*
How many pregnancies have you had? _____ How many live-births have you had? _____
Have you ever had an abortion? No ☐ Yes ☐ *if yes, how many?* _____
Have you ever experienced a miscarriage? No ☐ Yes ☐ *if yes, how many?* _____
Have you ever experienced a stillbirth? No ☐ Yes ☐ *if yes, how many?* _____
Have you ever had any difficulties after the birth of a child? No ☐ Yes ☐ *if yes, explain* _____
Are you taking any medication?

MEDICATION INFORMATION

Are you currently taking any medication (including birth control, over-the counter medications, & supplements)? No ☐ Yes ☐ *if yes, explain below:*

Medication Name	Dosage & Frequency	Prescribed For	Time Began	Length Used	Beneficial?
			/		No ☐ Yes ☐
			/		No ☐ Yes ☐
			/		No ☐ Yes ☐
			/		No ☐ Yes ☐
			/		No ☐ Yes ☐
			/		No ☐ Yes ☐
			/		No ☐ Yes ☐
			/		No ☐ Yes ☐

FAMILY MEDICAL HISTORY

Is there a family history of medical problems? No ☐ Yes ☐ I*f yes, please complete the information below:*

☐ None
☐ Alzheimer's Disease/Dementia
☐ Anemia/Blood Disorder
☐ Asthma
☐ Autoimmune Disorder
☐ Birth Defects
☐ Bleeding Problems
☐ Cancer/Tumor
☐ Diabetes
☐ Glaucoma
☐ Hearing Problems
☐ Heart Disease/Problems
☐ High Blood Pressure
☐ Hyperglycemia/ Hypoglycemia
☐ Kidney Problems
☐ Low Blood Pressure
☐ Migraine Headaches
☐ Narcolepsy
☐ Overweight/Obesity
☐ Reproductive Problems
☐ Rheumatic Fever
☐ Seizures/Convulsions
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Underweight
☐ Visual Problems
☐ Other *explain*_____

NARRATIVE ***for office use only***

_____

_____

_____

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ERROR: syntaxerror
OFFENDING COMMAND: %ztokenexec_continue

STACK:

true
-dictionary-