LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

All of the following pages of information must be completed as thoroughly as possible. If there are sections that you feel are unrelated to you personally, you may be asked to specify why, and to initial that section.

Jeffrey A. Watson, M.Ed., LCPC, LMFT, NCC, FAPA
Licensed Clinical Professional Counselor
Licensed Marriage and Family Therapist
National Certified Counselor
Clinical Fellow, American Association for Marriage and Family Therapy
Fellow, American Psychotherapy Association

Mary L. Watson, MS, LCPC, LMFT
Licensed Clinical Professional Counselor
Licensed Marriage and Family Therapist
National Certified Counselor

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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? ☐

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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? ☐

PRESENTING PROBLEM

Please identify your primary concerns or symptoms:

____

____

____

____

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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	☐	☐	☐	☐

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

NARRATIVE PRESENTING PROBLEM ***for office use only***

____
____
____
____
____
____

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)* ____________

2510 Continental Drive • Butte, MT 59701 • Phone: 406-782-4778 • Fax: 406-782-1318
Whitehall Office • P.O. Box 285 • 13 North Main Street • Whitehall, MT 59759

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: ______________________________________

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 ☐

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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: ______________________________

CHILDHOOD EXPERIENCES

Birthplace ______________________ Childhood Home(s) ______________________
Frequent Moves? No ☐ Yes ☐ Were you ever in foster care? No ☐ Yes ☐ *If 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:* ______________________

NARRATIVE FAMILY HISTORY ***for office use only***

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LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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
- ☐ Alcohol Use
- ☐ Bleeding
- ☐ Domestic Violence
- ☐ Drug Use
- ☐ Emotional Stress
- ☐ Gestational Diabetes
- ☐ High Blood Pressure
- ☐ Kidney Infection
- ☐ Psychiatric Impairment
- ☐ Tobacco Use
- ☐ Other *explain*_______________

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

- ☐ None
- ☐ Caesarean Delivery
- ☐ Difficult Delivery
- ☐ Induction
- ☐ Multiple Births
- ☐ Prolonged Labor
- ☐ Other *explain* _______________

CHILDHOOD HEALTH

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

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

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

DEVELOPMENT

Infancy Problems:

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

Delayed Milestones:

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

OTHER INFORMATION

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

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

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

- ☐ Child's Hospitalization
- ☐ Parent Incarceration
- ☐ Parent Mental Health Problems
- ☐ Parent Substance Abuse
- ☐ Partner Separation
- ☐ 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 ☐

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

NARRATIVE DEVELOPMENTAL HISTORY ***for office use only***

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SUBSTANCE ABUSE HISTORY

PERSONAL USE HISTORY

Substances Used	Age/First Use	Age/ Last Use	Average Amount	Frequency	Current
☐ 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) that 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 ☐

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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 ☐ *If 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 ☐ *If yes, who?*

Family Member	Maternal	Paternal	Drug of Choice	Active
____________	*Maternal* ☐	*Paternal* ☐	____________	No ☐ Yes ☐
____________	*Maternal* ☐	*Paternal* ☐	____________	No ☐ Yes ☐
____________	*Maternal* ☐	*Paternal* ☐	____________	No ☐ Yes ☐
____________	*Maternal* ☐	*Paternal* ☐	____________	No ☐ Yes ☐
____________	*Maternal* ☐	*Paternal* ☐	____________	No ☐ Yes ☐

NARRATIVE SUBSTANCE ABUSE HISTORY ***for office use only***

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

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
- ☐ Homeless
- ☐ Housing Dangerous/Deteriorating Housing
- ☐ Overcrowded
- ☐ Living Companions Dysfunctional
- ☐ Other *explain*________________

Who currently lives in the household? ____

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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
☐ Extended Relative ☐ Sibling *explain*________________

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 ☐ Substance-Using Friends
☐ Few Friends ☐ Supportive
☐ No 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: ______________________________

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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

☐ Adult Probation
☐ AWARE
☐ Big Brothers/Big Sisters
☐ Butte Sheltered Workshop
☐ Career Futures
☐ Department of Family Services
☐ Developmental Disabilities
☐ Family Outreach
☐ Four Cs
☐ Head Start/Early Head Start
☐ Health Department
☐ Housing Agency
☐ Human Resource Council
☐ Juvenile Probation
☐ NAMI
☐ None
☐ North American Indian Alliance
☐ PLUK
☐ Pre-Release
☐ Primary Health Care
☐ Safe Space
☐ Salvation Army
☐ Sylvan Learning Center
☐ Vocational Rehabilitation
☐ Western Montana Mental Health
☐ Youth Dynamics Inc.
☐ 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
☐ Conflicts about Finances
☐ Filing for Bankruptcy
☐ Impulsive Spending
☐ Large Indebtedness
☐ Poor Credit History
☐ Poverty or Below-Poverty Income
☐ Other *explain*________________

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 ☐

NARRATIVE SOCIO-ECONOMIC ***for office use only***

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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

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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? ______________________________

NARRATIVE LEGAL HISTORY ***for office use only***

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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* ________________

LMA

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BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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
________________	*Maternal* ☐ *Paternal* ☐	________________
________________	*Maternal* ☐ *Paternal* ☐	________________
________________	*Maternal* ☐ *Paternal* ☐	________________
________________	*Maternal* ☐ *Paternal* ☐	________________

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

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

SUBJECT INFORMATION

What subject is your/the client's favorite subject?
- ☐ English
- ☐ Math
- ☐ PE/Health
- ☐ Reading
- ☐ Science
- ☐ Social Studies

What subject is your/the client's least favorite subject?
- ☐ English
- ☐ Math
- ☐ PE/Health
- ☐ Reading
- ☐ Science
- ☐ Social Studies

What subject is your/the client's easiest subject?
- ☐ English
- ☐ Math
- ☐ PE/Health
- ☐ Reading
- ☐ Science
- ☐ Social Studies

What subject is your/the client's most difficult subject?
- ☐ English
- ☐ Math
- ☐ PE/Health
- ☐ Reading
- ☐ Science
- ☐ Social Studies

SOCIAL INTERACTION

How would you describe your/the client's social interaction? *(check all that apply)*
- ☐ Normal Social Interaction
- ☐ Alienates Self
- ☐ Associates with Acting-Out Peers
- ☐ Bullies Others
- ☐ Dominates Others
- ☐ Isolates Self
- ☐ Very Shy
- ☐ Other *explain* ______________________________

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

What disciplinarian actions have you/the client received? *(check all that apply)*
- ☐ Detention
- ☐ Discipline/"Pink" Slips
- ☐ Expulsion
- ☐ Legal Charges/Arrest
- ☐ Office Referral
- ☐ Parent/Guardian Contact
- ☐ School Meeting
- ☐ SRO Contact
- ☐ Suspension (In-School)
- ☐ Suspension (Out-of-School)
- ☐ Other *explain* ________________

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 ☐

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

NARRATIVE EDUCATIONAL HISTORY ***for office use only***

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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? ____

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

FUTURE EMPLOYMENT

What occupational goals do you/the client have for the future? ______________________________

What actions have you/the client taken to pursue that goal? ______________________________

NARRATIVE EMPLOYMENT STATUS & HISTORY ***for office use only***

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PSYCHIATRIC

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	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 ☐

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

Treatment	Treatment Facility/Provider	Year	Length of Treatment	Beneficial?
☐ 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? ______________________________
____

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* ________________

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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 ☐ If *yes, please explain:*
____

Have you/the client ever been prescribed medication for psychological symptoms? No ☐ Yes ☐ If *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 ☐

FAMILY PSYCHIATRIC HISTORY

Is there a family history of mental health problems and/or psychiatric illness? No ☐ Yes ☐ If *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 ________________	☐	☐	☐	☐	☐	☐

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

NARRATIVE PSYCHIATRIC ***for office use only***

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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* ____

LIFE MANAGEMENT ASSOCIATES, LLC

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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 ☐ I*f yes, explain:*
____

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 ☐

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

FAMILY MEDICAL HISTORY

Is there a family history of medical problems? No ☐ Yes ☐ *If 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 MEDICAL ***for office use only***

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YOUR STRENGTHS/WEAKNESSES

CLIENT STRENGTHS

- ☐ Accepts Guidance/Feedback
- ☐ Calm
- ☐ Capable of Independence
- ☐ Clear Thinking
- ☐ Confident
- ☐ Cooperative
- ☐ Expressive/Articulate
- ☐ Good Personal Care Habits
- ☐ Insightful
- ☐ Integrated Moral Values
- ☐ Intelligent
- ☐ Motivated for Change
- ☐ Physically Healthy
- ☐ Positive Support Network
- ☐ Reasonable Judgment
- ☐ Reliable
- ☐ Responsible
- ☐ Sociable
- ☐ Stable Living Environment
- ☐ Stable Work History
- ☐ Supportive Family
- ☐ Varied Interests
- ☐ Other *explain*

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CLIENT WEAKNESSES

- ☐ Aggressive
- ☐ Chaotic Living
- ☐ Concrete Thinking
- ☐ Defensive
- ☐ Demanding
- ☐ Dependent
- ☐ Distrustful
- ☐ Easily Distracted
- ☐ Hostile
- ☐ Illiterate
- ☐ Impulsive
- ☐ Indecisive
- ☐ Intellectual Deficits
- ☐ Irresponsible
- ☐ Lacks Insight
- ☐ Lacks Moral/Ethical Values
- ☐ Lacks Social Skills
- ☐ Needs Close Supervision
- ☐ Negative Peer Group
- ☐ No Support Network
- ☐ Non-Supportive Family
- ☐ Not Motivated to Change
- ☐ Not Open/Articulate
- ☐ Poor Health
- ☐ Poor Hygiene/Grooming
- ☐ Poor Judgment
- ☐ Unreliable
- ☐ Unstable Employment History
- ☐ Very Narrow Interests
- ☐ Other *explain*

____
____
____

I have completed the above to the best of my ability and fully understand the importance of this information. **All of the information was completed as thoroughly as possible. If there are sections that you feel are unrelated to you personally, you may be asked to specify why, and to initial the section.**

____ ________/________/________
Client Signature Date

____ ________/________/________
Parent/Legal Guardian Signature *mandatory if client is a minor* Date

____ ________/________/________
Therapist/Representative of Life Management Associates, LLC Date