Date:

FRANCISCAN COMMUNITY COUNSELING
BIOPSYCHOSOCIAL HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Primary Physician: **Telephone Number:** **Who referred you?**	**Current physical health:** Good ☐ Fair ☐ Poor ☐

PHYSICAL/MENTAL HEALTH HISTORY

Is there any history of the following in the family? ☐ Thyroid problems ☐ Cancer ☐ Diabetes ☐ Headaches ☐ Heart disease ☐ High blood pressure ☐Head trauma
List any medical problems that other doctors have diagnosed:
Have you had any prior outpatient psychotherapy/counseling? Yes ☐ No ☐ **Have you had any prior inpatient treatment for mental health?** Yes ☐ No ☐

Year	Reason	Provider/Facility

Are there any risk factors?	☐ Yes	☐ No
☐Homicidal ideation/plan/means		
☐Suicidal ideation/plan/means		
☐Grave disability		
☐Previous suicide attempts		

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Medication	Dosage	Frequency Taken
Allergies or adverse side effects to medications:		
Medication	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
	How often do you exercise per week?					
	What kind of exercises?					
Diet	What foods do you usually eat?					
	What beverages do you usually drink?					
	Have you had any significant weight gain or loss?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda		
	Number of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you used any of the following substances?	☐ Yes	☐ No
	☐ amphetamines ☐ barbiturates ☐ cocaine ☐ hallucinogens ☐ inhalants ☐ marijuana ☐ PCP ☐ unauthorized prescription medications Frequency of use:		

TRAUMA HISTORY

Have you witnessed a crime and/or violence? If yes, please describe:	☐ Yes	☐ No
Have you been the victim of a crime or violence? If yes, please describe:	☐ Yes	☐ No
Do you have history of other trauma, sexual abuse, and/or physical abuse? If yes, please describe:	☐ Yes	☐ No
What do you believe are your strengths, abilities, and positive qualities?		
Any additional information that you would like your therapist to know:		

PRESENT STRESSORS

☐ Relationship	☐ Educational	☐ Occupational
☐ Housing	☐ Economic	☐ Access to Service
☐ Legal/Law Enforcement	☐ Other	