BIOPSYCHOSOCIAL QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive understanding of your life experience, background, and medical health issues. Responding to these questions as completely as you can will help your clinician gain an understanding of the problems for which you are seeking help and of important events in your life. Some of the questions deal with alcohol and drug use, depression and suicide, and being the victim of a violent crime, including sexual assault. It is possible that these questions might make you feel uncomfortable. You may skip any question you do not wish to answer.

Your responses will remain strictly confidential and will become part of your medical record. Please return this form when completed by mailing it in the self addressed envelope; faxing it to 307-265-4480; or bringing it with you at your first appointment. Thank you.

Your name (first and last)	Age	Date of Birth	Today's Date
Home address, city, state, and zip code			

Home Phone:	Work Phone:	Cell Phone:

Which number should be called if it is necessary to change an appointment or leave a message? ☐ Home ☐ Work ☐ Cell

CURRENT CONCERNS

Briefly describe the problem you would like to address:
What factors led you seek treatment at this time? ☐ Legal Problems ☐ Health Problems ☐ Financial Problems ☐ Relationship Problems ☐ School Problems ☐ Work problems ☐ Other (please explain)
Who referred you to Wyoming Recovery?
List the substances you have used in the past seven days:
List the substances you have used in the past 24 hours:

PREVIOUS TREATMENT

Tell us about your previous mental health or substance abuse treatment

Date of Treatment	Name of Treatment Provider or Center	Reason and type of Treament (Residential, Detox, Outpatient, etc)	Response to Treatment

What was your longest period of sobriety?	How long ago did it end?

SUBSTANCE USE/ADDICTION HISTORY

Check each substance that you are presently using or have used in the past

☐ Alcohol (including beer and wine)	☐ Depressants (Valium, Xanax, etc)	☐ Stimulants (speed, Meth, etc)
☐ Cocaine (Powder, crack, etc)	☐ Marijuana (spice)	☐ Hallucinogens (Acid, Mushrooms, Ectasy, Peyote)
☐ Inhalants (poppers, paint, glue, etc)	☐ Nicotine (smoked, chewed, smokeless)	☐ Opiates (Pain meds, heroin, oxy, Percocet)
☐ other: List	☐ other: List	☐ other: List

For each substance that you checked list the following (use back of page if necessary)

Substance:	Age first used:	Date last used:
Current Craving: ☐ **none** ☐ **moderate** ☐ **strong** Method: ☐ **Oral** ☐ **Smoked** ☐ **Snorted** ☐ **Injected** ☐ **Other (specify)**		
Past pattern of use (frequency and quantity)		
Current pattern of use (frequency and quantity)		
Substance:	Age first used:	Date last used:
Current Craving: ☐ **none** ☐ **moderate** ☐ **strong** Method: ☐ **Oral** ☐ **Smoked** ☐ **Snorted** ☐ **Injected** ☐ **Other (specify)**		
Past pattern of use (frequency and quantity)		
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Current Craving: ☐ **none** ☐ **moderate** ☐ **strong** Method: ☐ **Oral** ☐ **Smoked** ☐ **Snorted** ☐ **Injected** ☐ **Other (specify)**		
Past pattern of use (frequency and quantity)		
Current pattern of use (frequency and quantity)		

Have you ever-Injected Drugs? ☐Yes ☐ No	If yes, which ones?
What is your substance of choice?	

Reviewed by: ____________________________ Date:____________ Reviewed by: ____________________________Date:__________

Do you have a history of any of these other additctions? if so check:

☐ Codependency ☐ Overeating/eating disorder ☐ Workaholic ☐ Video games ☐ Internet surfing ☐ Pornography
☐ Gambling ☐ Spending ☐ Shopping ☐ Sexual ☐ Other: ____________________________

Have you ever received treatment for any of the above addictions, if so, when and where?

Triggers to use

Check which factors lead you to use

☐ Boredom ☐ Fear ☐ Stress ☐ Need to relax ☐ Loneliness ☐ Panic attacks ☐ Inhibition ☐ Social anxiety
☐ Depression ☐ Hopelessness ☐ Other (please explain)

CONSEQUENCES AS A RESULT OF DRUG/ALCOHOL USE (CHECK ALL THAT APPLY)

☐ Hangovers	☐ Left school	☐ Using/carrying a weapon
☐ DTs/Shakes	☐ Incarcerations	☐ Assaulting others
☐ Blackouts	☐ DUI's	☐ Stroke
☐ Binges	☐ Reckless driving	☐ Sleep problems
☐ Overdoses	☐ Auto accidents	☐ Liver disease
☐ Increased Tolerance	☐ Breaking the law	☐ Hep C or HIV/AIDS
☐ Delusions/hallucinations	☐ Unplanned pregnancy	☐ GI or esophageal bleeding
☐ Falling down when drunk	☐ Rape	☐ Sexual acting out
☐ Loss of Control	☐ STD's	☐ Drug dealing
☐ Loss of self respect	☐ Arrests	☐ Relationship problems
☐ Other: please explain:		

OBSTACLES TO RECOVERY

Do you believe any of the following will make it more difficult for you to stop using alcohol or drugs?

☐ Living with someone who uses alcohol or drugs ☐ Having friends who use alcohol or drugs
☐ Experiencing a great deal of job or home stress ☐ Being depressed or anxious
☐ Having strong cravings for alcohol or drugs ☐ Having few or no hobbies

Do you have any communication difficulties which could affect your recovery effort (ex speech, visual, or hearing impairment)? If so- what

During treatment, what support systems (family, friends, neighbors, church, etc) will be available to help you with your recovery?

FINANCIAL AND LEGAL STATUS

Do you have any current legal problems (describe)?

Any past legal charges (describe)?

Any past court ordered treatment? If yes who was it ordered by, what was the offense, and what was the length of time?

Are you experiencing any current financial problems? ☐ No ☐ Yes (describe)

ENVIRONMENT AND HOME

Marital Status: ☐ Single ☐ Married ☐ Living as married ☐ Divorced ☐ Separated ☐ Other		Who is currently living with you?
List the names and ages of your children:	Do you have custody of your minor children? ☐ yes ☐ no	
What childcare arrangements do you have?	How many close friends do you have?	Are you satisfied with this number?

Has there been violence/physical abuse in your current relationships? ☐ Yes ☐ No Your past relationships? ☐ Yes ☐ No

What is the primary language used in your home? Secondary language?

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SOCIAL

Rate how supportive you feel the following people are in your life using a scale from 1-5 with 5 being strong:

	Immediate Family		Extended Family		Friends
	School		Work		Religious/Spiritual Advisors

Other:

SEXUAL HISTORY

What is your sexual orientation?	Are you comfortable with your sexual orientation? ☐ Yes ☐ No (explain)	Do you practice safe sex? ☐ Yes ☐ No Type of contraception:

Are you sexually acitve ? ☐ Yes ☐ No

If there is significant information regarding your sexual history – List here

VOCATIONAL, EDUCATIONAL, AND MILITARY HISTORY

Where are you employed?	Job Title?	Do you like your job? ☐ Yes ☐ No (explain)
Have you been in the military? ☐ No ☐ Yes – (list branch)	Highest Rank?	Type of Discharge?

Highest Level of Education: ☐ Did not complete high school ☐ Completed College ☐ Technical Training ☐ Obtained GED
☐ Completed high school ☐ Completed graduate school

Do you have difficulties reading or writing? ☐ Yes ☐ No

Have you ever been diagnosed with a learning disorder? ☐ Yes ☐ No Did you have problems in school (if yes explain below)? ☐ Yes ☐ No

RELIGION AND SPIRITUAL ORIENTATION

Is spirituality a significant part of your life? ☐ Yes ☐ No	What denomination are you affiliated with – if any?	Do you attend regularly? ☐ Yes ☐ No

How would you describe your spirituality?

LEISURE AND RECREATION

List your interests or hobbies:

What social activities do you participate in?

ETHNIC AND CULTURAL INFORMATION

What is your ethnic group? ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Caucasian ☐ Other:

What if any, cultural beliefs do you have that could be relevant to your treatment?

What are your strengths, such as talents, skills or personal characteristics?

Reviewed by: ____________________________ Date:____________ Reviewed by: _____________________________Date:__________

PSYCHOLOGICAL

Check if you have a history of or have experienced any of the following problems:

☐	Depressed Mood	☐	Intrusive memories, thoughts	☐	Avoiding thoughts, feelings	☐	Avoiding people, places
☐	Nightmares	☐	Flashbacks	☐	Numbing/detachment	☐	Irritablity
☐	Trouble displaying emotions	☐	History of depressed mood	☐	History of animal abuse	☐	History of tantrums
☐	History of hurting others	☐	Other: describe				

What are your sleep patterns? ☐Normal ☐Sleeping too much ☐Sleeping too little

What is your ability to concentrate? ☐Normal ☐ Difficulty concentrating

Would you describe your energy level as: ☐Low ☐ Average/ Normal ☐ High

Have you ever been suicidal? ☐ Yes ☐ No Have you ever attempted suicide ☐ Yes ☐ No

Do you have suidical thoughts or plans now? ☐ Yes ☐ No If you answered yes, please explain:

FAMILY HISTORY

Are your parents still living? ☐ Yes ☐ No (if no, when and how old were they when they died)?

Please list the names and ages of your siblings; if they are living; and if deceased their age at death

Name	Age	Living	How would you describe your relationship?
		☐ Yes ☐ No (age at death?)	
		☐ Yes ☐ No (age at death?)	
		☐ Yes ☐ No (age at death?)	
		☐ Yes ☐ No (age at death?)	
		☐ Yes ☐ No (age at death?)	
		☐ Yes ☐ No (age at death?)	
		☐ Yes ☐ No (age at death?)	

Would you describe your childhood home as : ☐ Loving ☐ Comfortable ☐ Chaotic ☐ Abusive ☐ Supportive ☐ Other (describe below)

What is your families ethnic/ancestral/tribal background and what meaning does this have in your life?

Family History of Substance Abuse and Mental Illness (place a check in the column if condition is present)

	Mother	Father	Siblings	Grandparents	Children	Other
Alcohol						
Suicide						
History of Mental Illnesses/ Problems such as:						
Depression						
Schizophrenia						
Bipolar Disorder						
Alzheimer’s						
Anxiety						
ADHD						
Learning Disorders						
School Behavior Problems						
Incarceration						
Other						

Reviewed by: ____________________________ Date:____________ Reviewed by: _____________________________Date:__________

HISTORY OF TRAUMA	
While you were growing up, during the first 18 years of life:	
Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you or act in a way that made you afraid that you might be physically hurt?	☐ Yes ☐ No
Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you or ever hit you so hard that you had marks or were injured?	☐ Yes ☐ No
Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way or attempt to actually have oral, anal, or vaginal intercourse with you?	☐ Yes ☐ No
Did you often or very often feel that : No one in your family loved you or thought you were important or special or that your family didn't look out for each other, feel close to or support each other?	☐ Yes ☐ No
Did you often or very often feel that: You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you, or take you to the doctor if you needed?	☐ Yes ☐ No
Were your parents ever separated or divorced?	☐ Yes ☐ No
Was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her; or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard; or ever repeatedly hit at least or threatened with a gun or knife?	`☐ Yes ☐ No
Did you live with anyone who was a problem drinker or alcoholic or who used drugs?	☐ Yes ☐ No
Did a household member go to prison?	☐ Yes ☐ No

Reviewed by: ____________________________ Date:____________ Reviewed by: ____________________________Date:__________

MEDICAL HISTORY

Your name (first and last)

Name of your Primary Care Provider: Phone:

Date of Last Visit: Reason: Date of Last Physical?

Please list any medical problems that doctors/medical providers have diagnosed:

List any current medical problems you are concerned about:

Have you had any worrisome physical symptoms when using alcohol or drugs?

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (use other side of page if needed)

Name of Drug	Name of Drug

List any medication Allergies

Name the Medication	Reaction you experience

List any Allergies to food/environment, etc

Name the Allergen	Reaction you experience

List any surgeries you have had (use other side of page if needed)

Year	Surgery/Reason	Outcome since surgery
		☐ Better ☐ Worse ☐ Same
		☐ Better ☐ Worse ☐ Same
		☐ Better ☐ Worse ☐ Same

Other hospitalizations (other than for addiction or substance abuse treatment)

Year	Reason	Outcome since hospitalization
		☐ Better ☐ Worse ☐ Same
		☐ Better ☐ Worse ☐ Same
		☐ Better ☐ Worse ☐ Same

Date of last skin test (PPD) for tuberculosis: ☐ Positive ☐ Negative ☐ Never had one

Date of Last HIV test: ☐ Positive ☐ Negative ☐ Never had one

Date of Last Hepatitis test: ☐ Positive ☐ Negative ☐ Never had one

Have you ever had a blood transfusion? ☐ Yes (date:) ☐ No

Reviewed by: ____________________________ Date:____________ Reviewed by: _____________________________Date:__________

Have you ever shared needles? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please answer questions with a ☒ if your answer is yes

Question		Question	
Have you ever had jaundice?	☐	Do you have difficulty walking?	☐
Have you had abnormal bruising, bleeding or healing?	☐	Have you ever had pitch black stools or blood in your stools?	☐
Do you have problems with clear vision, distance or reading?	☐	Have you ever vomited blood or 'coffee grounds'?	☐
Do you have a serious problem hearing?	☐	Do you have frequent heart burn or acid reflux?	☐
Have you had serious nose bleeds?	☐	Have you had any kind of liver disease?	☐
Have you had hoarseness or change in your voice that does not go away in a day or two?	☐	Have you been diagnosed with pancreatitis	☐
Have you had difficulty chewing or swallowing solid food?	☐	Have you had stomach or duodenal ulcers?	☐
Have you had problems with nausea or vomiting?	☐	Have you had any inflammatory bowel disease?	☐
Have you been diagnosed or do you feel you have an eating disorder?	☐	Have you had problems with constipation?	☐
Have you been diagnosed with diabetes?	☐	Have you had problems with diabetes	☐
Do you suffer from chronic pain of your bones, muscles, or joints?	☐	Do you use laxatives more than twice a week?	☐
Do you have COPD or asthma requiring frequent medication?	☐	Do you have blood in your urine?	☐
Do you have difficulty breathing when climbing stairs?	☐	Do you have any difficulty or pain with urination?	☐
Have you had a cough lasting over two weeks?	☐	Do you have any difficulties with sexual function?	☐
Do you experience shortness of breath?	☐	Have you ever been diagnosed with a sexually transmitted disease?	☐
Have you ever had a serious heart problem?	☐	Is there a chance you might be pregnant now?	☐
Do you have chest pain, tightness, or pressure with exertion?	☐	Have you ever had a significant head injury?	☐
Have you been diagnosed with high blood pressure?	☐	Do you have frequent or severe headaches?	☐
Have you had serious or persistent fluid retention?	☐	Have you ever had a seizure or loss of consciouslness ?	☐
Have you had episodes of rapid or irregular heart beats?	☐	Have you ever had a problem with weakness or paralysis of part of your body?	☐
HavHave you ever fallen or hurt yourself after drinking or using drugs?	☐	Have you ever had any type of cancer?	☐
Do you have sores or growths in your mouth or throat or elsewhere that concern you?	☐	Have you had persistent or recurring bleeding? If yes…where:	☐

If you answered "YES" to any of the questions above, or if you have other medical problems that bother you that are not listed on this page, please describe below:

NUTRITION

What is your current weight? __________ What is your usual weight? _______________ Height? _____________

Have you gained or lost 10 or more pounds in the past month?
Yes ☐ No ☐
Could you be pregnant? Yes ☐ No ☐
Are you on a modified diet? Yes ☐ No ☐
How would you describe your appetite? Good ☐ Average ☐ Poor
Has your appetite changed recently? Yes ☐ No ☐

If you answered yes to any of these questions, please clarify:

Reviewed by: ____________________________ Date:____________ Reviewed by: _____________________________Date:__________