THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Department of Psychiatry
Outpatient Clinic
OSU Harding Hospital
1670 Upham Drive
Columbus, OH 43210
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BIOPSYCHOSOCIAL QUESTIONNAIRE

Thank you for taking the time to complete these questions. We use this information along with what we discuss in your initial assessment session to inform treatment planning.

Name _____

Date of Birth: _____/_____/_____

Age: _____

Race/Ethnicity _____

Current Address: (Students, please list your campus address as well as parent's address if applicable):

Street: _____ City: _____ Zip:_____

Street:_____ City:_____ Zip:_____

Phone Number(s): Home ( ) _____ Cell: ( ) _____ Other: ( ) _____

Preferred contact number? ( ) _____

YES/NO ***Will you allow your treatment team members here (Your doctor, therapist, nurses, staff) to leave you a message on your answering machine/voicemail which may contain confidential information about your treatment (such as rescheduling of appointments, instructions regarding medications, lab results, etc.) at one of these numbers?***
If Yes, which one(s) _____

****

PRESENTING CONCERN(S)

- Who referred you to this clinic? _____
- What is the major difficulty for which you are seeking help at this time? _____
  _____
  _____
- What are you hoping will be accomplished from today's appointment?
  _____

Sometimes aspects of people's background or identity can make their problems better or worse.
Background or identity means the communities you belong to, the languages you speak, where you and your family are from, race and ethnic background, your gender or sexual orientation or your faith or religion. For you, what are the most important aspects of your identity?

_____

_____

_____

_____

_____

Primary language spoken in the home: _____

Are there any kinds of support that make the problems you are having better such as support from family, friends or others? Are there any stressors that make it worse, such as difficulty with money or family or job stress?

_____

_____

_____

_____

_____

• Psychotherapy or counseling – LIST CURRENT AND PAST PSYCHOTHERAPY

DATE STARTED/DATE STOPPED	TYPE	NAME OF THERAPIST	RESPONSE (was it helpful?)
_____to_____	_____	_____	_____
_____to_____	_____	_____	_____
_____to_____	_____	_____	_____
_____to_____	_____	_____	_____

CURRENT PSYCHIATRIC MEDICATIONS

Name: Medical Record #: DOB:

NAME	DOSE (mg)	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT NON-PSYCHIATRIC MEDICATIONS

NAME	DOSE (mg)	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDICATIONS

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____

- Past Psychiatric Medications: ONLY LIST MEDICATIONS YOU ARE **NOT** CURRENTLY TAKING
  (Please include all anti-depressants, anti-anxiety medications, anti-psychotics, mood stabilizers/anti-seizure medications, stimulants, sleep aids):

NAME	**DOSE (mg)**	**FREQUENCY**	**DATE STARTED/DATES STOPPED**	**RESPONSE/SIDE EFFECTS**
_____		_____	_____**to**_____	_____
_____		_____	_____to_____	_____
_____		_____	_____to_____	_____
_____		_____	_____to_____	_____
_____		_____	_____to_____	_____
_____		_____	_____to_____	_____

YES/NO Have you ever seen a psychiatrist before? If yes, name(s) and dates seen:

_____

YES/NO Do you have a current psychiatrist? If yes, who? _____

Seeing since (date) _____ Last seen (date) _____

YES/NO Have you ever been in a Partial/Intensive Outpatient Program (IOP?)

Name of program(s): _____ Dates: _____

YES/NO Have you ever had ECT (electroconvulsive therapy)? _____

☐ I have never taken any anti-depressants, anti-anxiety medications, anti-psychotics, stimulants, mood stabilizers/anti-seizure medications, or sleep aids.

PAST PSYCHIATRIC HISTORY

- Past Diagnoses: _____

  _____

  _____

YES/NO Have you ever been hospitalized for psychiatric reasons?
If yes, please list including your first as well as your most recent hospitalization.

DATE(S)	HOSPITAL	REASON (i.e. suicide attempt, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sometimes people get so distressed that they have thoughts about hurting or killing themselves.

YES/NO Have you ever had thoughts of hurting or killing yourself?
YES/NO Have you ever attempted suicide?
If yes, how many times and when? _____
_____
YES/NO Have you ever cut or burned yourself on purpose, or injured yourself in other ways?
_____

****

SUBSTANCE HISTORY

YES/NO Do you use any drugs or alcohol for recreational purposes? (Examples include caffeine, nicotine, alcohol, marijuana, cocaine/crack, amphetamines, hallucinogens, heroin, inhalants, stimulants, pain medications and benzodiazepines)

If yes, please list the type of drug and the amount of frequency of current use.

Drug	Dose/Amount	Frequency of use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YES/NO Any drug or alcohol rehab? _____
If yes, when and what program? _____

PAST MEDICAL HISTORY

- Please list any medical conditions you have: _____
  _____
  _____
- Please list any surgeries you have had (what year?) _____
  _____

YES/NO Any history of major head trauma
YES/NO Any history of seizures?
YES/NO Do you exercise regularly? If so, what kind? _____
day per week: _____ Minutes per day _____

- Current method of birth control: _____

WOMEN ONLY:

YES/NO Are you currently pregnant? If yes, how many weeks? _____
If no, date of last menstrual period: _____
YES/NO Are you currently breastfeeding?: _____

****

FAMILY PSYCHIATRIC HISTORY

Please list any family members who have struggled with any psychiatric or addiction issues.

Family Member	**On Mother's or Father's side?**	**Diagnosis/Problem**	**Hospitalized?**	**Treatment?**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SOCIAL HISTORY

YES/NO When your mother was pregnant with you, were there any issues with the pregnancy or the birth? (i.e. prematurity, substance use, infection, etc.) _____

YES/NO Were there any delays in walking or speech? _____

YES/NO Have you ever been abused or witnessed abuse (physical/emotional/sexual)?
If yes, please describe (OPTIONAL) _____
_____

YES/NO Any special education classes in school? _____

YES/NO Have you been told you have any learning difficulties/impairments or had testing?

- How would you describe your childhood? (OPTIONAL) _____
  _____
  _____
  _____

- Highest level of education completed (*check all that apply*)
  - ☐ Elementary education, completed grade level _____
  - ☐ High school diploma
  - ☐ GED
  - ☐ AA degree
  - ☐ BA or BS in _____ from _____
  - ☐ Master's degree in _____ from _____
  - ☐ Doctoral degree in _____from _____
  - ☐ Other: _____

- Are you currently (*check all that apply)*:

  ☐ Employed full-time ☐ Student full-time ☐ Unemployed
  ☐ Employed part-time ☐ Student part-time
  ☐ Retired, since _____
  ☐ On disability, since _____ for _____

  - Job title and company (*if applicable*): _____
  - How many years with current employer:? _____

Current relationship status (single, married, divorced, in a relationship): _____

YES/NO Have you been divorced:
YES/NO Do you have children? If yes, what are their ages and genders?:

Age: _____ Gender: _____

Age: _____ Gender: _____

Age: _____ Gender: _____

Age: _____ Gender: _____

- What is your living situation? (Who lives in your home with you?): _____
  _____
- Are there any family relationships that are of particular concern for you? _____
  _____

YES/NO Have you ever been arrested?
YES/NO Have you ever spent time in prison?
YES/NO Are you currently on probation?
YES/NO Have you ever gotten a DUI?
YES/NO Have you ever served in the military? If yes, what branch? _____
Type of discharge _____ Did you see combat? YES/NO

- Were you raised in any particular religious/spiritual faith? _____
- What religious/spiritual faith do you identify with? _____
- Whom do you lean on during difficult times? (spouse, parents, siblings, friends, church, etc.):
  _____
- What do you do to cope with stress? _____
- What do you enjoy doing with your free time? _____
- What do you consider your strengths? _____
  _____
  _____