GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

I have been appointed Guardian Ad Litem, GAL by the court and therefore I have the courts authority to request pertinent information that will assist me in the process of investigating and determining "The Best Interest of the Minor Child/Children" in the legal matter before the court.

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 required to specify why and to initial that section. The process of gathering the necessary and important information requires your assistance and cooperation. In my role as Guardian ad litem, I will make every effort to be respectful and sensitive with information concerning you and or the minor child/children.

Any and all information provided to me as the GAL will be subject for consideration to be included in the final GAL report to the Court. All fees due for GAL services must be paid prior to the release of the final GAL report. Fees paid for GAL services up to and including the report does not include additional services such as court testimony, etc. The release of the final GAL report will be made simultaneously to the Court, to the Petitioner and their legal counsel and the Respondent, and their legal counsel.

Sincerely,

Jeffrey A. Watson, M.Ed., LCPC, LMFT, NCC, FAPA
Guardian ad litem
E-mail: jeffrey@lmallc.org

LIFE MANAGEMENT ASSOCIATES, LLC

LMA

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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? ☐

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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:

_____

_____

_____

_____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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	☐	☐	☐	☐

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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)* _____

LIFE MANAGEMENT ASSOCIATES, LLC

LMA

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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 ☐

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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: ____

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:* ______________________________

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

NARRATIVE FAMILY HISTORY *for office use only*

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*_____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

OTHER INFORMATION

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

☐ Full-time ☐ Overnight ☐ Other

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

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

☐ Child's Hospitalization ☐ Parent Substance Abuse

☐ Parent Incarceration ☐ Partner Separation

☐ Parent Mental Health Problems ☐ 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 ☐

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

_____

_____

_____

_____

_____

_____

_____

_____

SUBSTANCE ABUSE HISTORY

PERSONAL USE HISTORY

Substances Used Use	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 ☐

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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 ☐

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: 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 ☐

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

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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? _____

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
- ☐ Boy/Girlfriend
- ☐ Coworker
- ☐ Extended Relative
- ☐ Friend
- ☐ Parent
- ☐ Professional
- ☐ Sibling
- ☐ Spouse
- ☐ Stranger
- ☐ Other *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
- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other *explain* _____

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: _____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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

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***

_____

_____

_____

_____

_____

_

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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? _____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

NARRATIVE LEGAL HISTORY *for office use only*

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 = _____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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

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 ☐

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

_____

_____

_____

_____

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* _____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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? _____

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

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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 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 ☐

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

☐ Psychological Testing
Treatment Facility/Provider _____ Year _____ Length of Treatment _____ No ☐ Yes ☐ Beneficial?
Treatment Facility/Provider _____ Year _____ Length of Treatment _____ No ☐ Yes ☐ Beneficial?

☐ Therapeutic Group Home/ Therapeutic Foster Care
Treatment Facility/Provider _____ Year _____ Length of Treatment _____ No ☐ Yes ☐ Beneficial?
Treatment Facility/Provider _____ Year _____ Length of Treatment _____ No ☐ Yes ☐ Beneficial?

☐ 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*
_____

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

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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 _____	☐	☐	☐	☐	☐	☐

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

_____

_____

_____

_____

_____

_____

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 ☐ I*f yes, explain* _____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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*
_____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

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

_____

FEMALES ONLY ☐ N/A – client is a male

Are you pregnant? No ☐ Yes ☐ *If 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 ☐

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*_____

GAL BIOPSYCHOSOCIAL QUESTIONNAIRE FOR PARENTS

NARRATIVE MEDICAL ***for office use only***

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*

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*

BIOPSYCHOSOCIAL QUESTIONNAIRE FOR ASSESSMENTS

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