BACKGROUND QUESTIONNAIRE (AGE 18 AND OLDER)

Today's Date: _____

Name of person completing form: _____

Identification

Patient's Name: _____

Home Address: _____

City/State/ZIP: _____

Home Phone: _____

Phone: _____ Work/Cell Phone: _____

Email Address:_____ Preferred Method of Contact: □ Phone □ Email □ Both

Education Level: _____ Occupation: _____

Place of Business: _____

Birthdate: _____ Age: _____ Place of Birth: _____

Gender: _____ Race/Ethnicity: _____

Religion as a child:_____ Religion as an adult: _____

Marital Status: single engaged married separated divorced widowed

Date of marriage(s):_____

If divorced, are you remarried?_____ If yes, how many times?_____

Do you live: alone with parents with partner with non-romantic roommate_____

Do you live in: house apartment hotel room other_____

Partner's Age:_____ Partner's Gender:_____

Partner's Education Level: _____ Partner's Occupation: _____

Number of Children: _____

Name of Child	Age of Child	Gender of Child	Lives with you (y/n)

Primary Language Spoken at Home: _____

Other Languages Spoken:_____

List all members of the household:

Name	Relationship to Patient	Age

Person to contact in case of emergency (all information is kept confidential: person will only be called in the event of an emergency. Please see limits of confidentiality section of the consent for assessment/treatment form for details):
Name:_____ Phone Number:_____

Family Data

Siblings: Number of brothers_____brothers' ages:_____

Number of sisters_____ sisters' ages: _____

Mother's First Name: _____

Mother Living_____? If alive, give Mother's age:_____

If deceased, give her age at time of death: _____ Cause of death:_____

Relationship to Patient: Biological Parent Adoptive Parent Step Parent Other _____

Education Level: _____ Occupation: _____

Phone: _____ Work Phone: _____

Place of Business: _____

Father's First Name: _____

Father Living_____? If alive, give Father's age:_____

If deceased, give his age at time of death: _____ Cause of death:_____

Relationship to Patient: Biological Parent Adoptive Parent Step Parent Other _____

Education Level: _____ Occupation: _____

Phone: _____ Work Phone: _____

Place of Business:

_____

If you were adopted, age at which adoption occurred: _____

If parents are married, date of marriage: _____

If parents are not married:
Separated _____ Date _____
Divorced _____ Date _____
Never married _____

Educational History

Please list all of the schools you have attended

School	Dates/Grades Attended	Comments or Specific Reason Chose School?

Please place a check next to any problem that you currently exhibit (or caused difficulty in the past):
_____ Difficulty with reading
_____ Difficulty with spelling
_____ Difficulty with writing
_____ Difficulty with arithmetic
_____ Difficulty with other subjects (please list) _____
_____ Dislike school

Have you ever been diagnosed with a learning disability? If yes, what type and when:

_____

Employment History:

Please list all your primary positions since high school/college

Dates	Position	Reasons for Leaving

Presenting Problem

Briefly describe your current difficulties:

When did this problem first become of concern to you?_____

_____

When was the problem first noticed?_____

What seems to make the problem worse? _____

Have you received an evaluation or treatment for the current problem? _____ Yes _____ No

If yes, when and with whom?_____

_____

_____

Are you currently on medication? _____ Yes _____ No

If yes, please list medication, dosage, and date started in the table below.

_____

Please list any previous psychological or psychiatric treatment that you have received

Name of Doctor, Clinic, Hospital etc.	Location	Dates	Services Provided

Please list any other medications that you take for psychiatric or emotional problems

Name of Medication	Reason Prescribed	Dosage	Dates	Results/ Side Effects	Prescribing Physician

Primary Care Physician:
Name:
Office Location: **Phone Number:**
Date of last physical examination:
Current Height: Current Weight:
Any recent increase or decrease in weight?

Medical History

Place a check next to any illness or condition that you have had, also note the approximate date or age of the illness:

Allergies *Age of Onset/Dates*

_____ Food Allergies (Describe) _____ _____
_____ Hay Fever _____
_____ Household Allergies _____
_____ Other (Describe) _____ _____

Blood Disorders

_____ Anemia _____
_____ Hemophilia _____
_____ Bleeding Problems _____
_____ Other (Describe) _____ _____

Age of Onset/Dates

Dermatological

_____ Acne _____
_____ Eczema _____
_____ Psoriasis _____
_____ Hives _____
_____ Other (Describe) _____ _____

Cardiovascular/Pulmonary

_____ Heart Disease (Describe) _____ _____
_____ High/Low Blood Pressure _____
_____ Mitral Valve Prolapse _____
_____ Irregular Heart Beat _____
_____ Asthma _____
_____ Cystic Fibrosis _____
_____ Hyperventilation _____
_____ Other (Describe) _____ _____

Conditions of Childhood

_____ Chicken Pox _____
_____ Diphtheria _____
_____ German Measles _____
_____ Measles _____
_____ Mumps _____
_____ Whooping Cough _____
_____ Stuttering _____
_____ Other (Describe) _____ _____

Endocrine

_____ Thyroid Condition _____
_____ Diabetes: ___ Type I ___ Type II _____
_____ Other (Describe) _____ _____

Eye, Ear, Throat

_____ Impaired Vision _____
_____ Impaired Hearing _____
_____ Frequent Earaches _____
_____ Ear Tubes _____
_____ Frequent Sore Throats/Colds _____
_____ Strep Infection _____
_____ Other (Describe) _____ _____

Gastrointestinal

_____ Stomachaches _____
_____ Constipation _____
_____ Diarrhea _____
_____ Soils Self _____
_____ Reflux _____
_____ Irritable Bowel Syndrome _____
_____ Crohn's Disease _____
_____ Other (Describe) _____ _____

Any foods that you avoid? _____

Genitourinary

_____ Urinary Tract Infections _____
_____ Kidney Problems _____
_____ Enuresis (Wetting) _____ Day _____ Night _____
_____ Other (Describe) _____ _____

Joints and Muscles

_____ Arthritis _____
_____ Broken Bones _____
_____ Bone or Joint Disease _____
_____ Other (Describe) _____ _____

Neurological

_____ Head Trauma/Injury (Describe) _____ _____
_____ Frequent or Severe Headaches _____
_____ Epilepsy _____

_____ Seizure/Other Seizure Disorder _____
_____ Tics _____
_____ Fainting Spells/Dizziness _____
_____ Loss of Consciousness _____
_____ Paralysis _____
_____ Other (Describe) _____ _____

Reproductive

_____ First Period _____
_____ Premenstrual Syndrome/Problems _____
_____ Irregular Cycle _____
_____ Other (Describe) _____ _____

Other

_____ Hospitalizations (Describe) _____ _____
_____ Surgeries (Describe) _____ _____
_____ Emergency Room Visit (Describe) _____ _____
_____ Cancer (Describe) _____ _____
_____ Meningitis _____
_____ Convulsions _____
_____ Other _____

Family Medical History

Place a check next to any illness or condition that any member of your immediate family has had. If you check an item, please note the family member's relationship to you (e.g., Mother, Father, Sibling #1, Sibling #2, Maternal grandparent, etc).

Medical Conditions

_____ Cancer Family member(s): _____
_____ Diabetes Family member(s): _____
_____ Cardiovascular Problems Family member(s): _____
_____ Neurological Problems Family member(s): _____
_____ Other Family member(s): _____

Psychological/Behavioral Problems

_____ Depression Family member(s): _____
_____ Bipolar Disorder Family member(s): _____
_____ Anxiety Family member(s): _____
_____ Obsessive-Compulsive Family member(s): _____
_____ Panic Attacks Family member(s): _____
_____ Learning Problems Family member(s): _____
_____ Behavior Problems Family member(s): _____
_____ ADHD/ADD Family member(s): _____
_____ Autism/Aspergers Family member(s): _____
_____ Schizophrenia Family member(s): _____
_____ Mental Retardation Family member(s): _____
_____ Suicide Attempts Family member(s): _____
_____ Alcoholism Family member(s): _____
_____ Drug Addiction Family member(s): _____
_____ Legal Problems Family member(s): _____
_____ Other Family member(s): _____

Please provide specific information regarding any of the conditions that you checked for family history, including onset, treatment, and any impact on family functioning:

Other Information

What are your hobbies and interests?

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

What activities would you like to engage in more often than you do at present?

1. _____ 2. _____ 3. _____

What activities do you like least?

1. _____ 2. _____ 3. _____

Have you ever been in trouble with the law? _____ Yes _____ No

If yes, please describe briefly: _____

Is there any other information that you think may be helpful for us to know to help you?_____

_____

_____

_____