♥ Adult Background Information ♥

Today's Date:_____

<Identifying Information>

The following information is used to best determine a treatment plan. Completing this form as fully and accurately as possible will help facilitate this process. If you feel uncomfortable answering any of the questions, feel free to put an "X" through those sections.

Name(Last, First):	Date of Birth:_____ Age:_____ Gender: M_____ F_____
Address: _____ OK to send letters: Yes_____, No_____	
Home Phone:_____ OK to leave messages: Yes_____, No_____ Cell Phone:_____ OK to leave messages: Yes_____, No_____ Work:_____ OK to leave messages: Yes_____, No_____ Email Address: OK to email: Yes_____, No_____	
Ethnicity: African American ( ), Asian ( ), Bi-racial ( ), Caucasian ( ) Hispanic/Latin ( ) Native American ( ), Other(explain):	
Marital Status: Single__, Engaged__, Married__, Re-married__, Separated__, Divorce__, Widowed__, Partnered/Other__	
Spouse's Name:_____, Age_____, Spouse's occupation: Spouse's Contact Number: OK to communicate: Yes_____, No_____	
Person we should contact in the event of an emergency: Name:_____ Relationship:_____ Phone number:	
Current Employment:	
Where were you born?	
How long have you lived in the city you live in currently?	
Who do you live with?	
What do you like to do for fun? (hobbies, activities)_____	
Is there anything about your current or past relationships that would be helpful to know in counseling? _____ _____	

<Referral Information>

1. By whom where you referred?_____
2. Have you been seen previously for psychological or psychiatric treatment? Y/N:___
   If yes, previous professional (Agency): _____
   Phone:_____ When:_____ How long:_____
   Was an evaluation completed?_____ What type of evaluation?_____
   (If yes, please attach a copy of evaluation to this questionnaire)
   Will you grant permission for us to consult with this professional:
   (If yes, please sign attached "Authorization to request confidential information" form)
3. Describe your major concerns, including duration of those concerns and any previous attempts to resolve them.

_____
_____
_____
_____

4. Please indicate with "X" mark how severe your concerns are at this point in time:
   _____ Mildly upsetting
   _____ Moderately severe
   _____ Very severe
   _____ Extremely severe
   _____ Incapacitating
5. How often does the problem behavior occur? (5x/day, 2x/week, etc)_____
6. How long have you had this problems?_____
   _____
7. How is this problem affecting you at home? At work? In relationship?

_____
_____
_____
_____
_____
_____

8. Please describe below any major life stressors that have occurred to you or your family during the past year.

_____
_____
_____

9. What goals do you have for your treatment?

_____
_____
_____

10. Anything else you think I need to know?

_____
_____

11. Please describe your strengths

_____
_____

<Background Information>

Family History

1. Please list household members, beginning with the oldest member and include yourself

Name	Date of Birth	Age	Gender	Relationship

2. Please list other persons closely involved with you and your family but not living in your home (e.g., older children, grandparents, sisters, teachers, religious leaders, etc.)

Name	Relationship to Child	Place of Residence	Frequency of Visits

3. How long have you lived at the current address?_____
4. Please describe any religious or cultural beliefs you would like incorporated into your treatment.
   _____
5. Marital Status: Single__, Engaged__, Married__, Re-married__,
   Separated__, Divorce__, Widowed__, Partnered/Other__
6. Spouse's age____, Spouse's occupation:_____, Length of relationship_____
   Describe strengths of current relationship:_____
   _____
   Describe areas of concern of incompatibility in the relationship:_____
   _____
   Give details of any previous marriages (length, children, etc)_____
7. Are there any fearful of distressing experiences regarding your family life which stand out in your mind which were not previously mentioned? (briefly describe)
   _____
8. Are there other family members that you are close with?_____
9. Do you have people outside your biological family that you feel are "like family" and in whom you can confide? _____

Extended Family History

Parents

Mother's Name:_____ Age:_____, Heath issues?_____ Occupation:	Father's Name:_____ Age:_____, Heath issues?_____ Occupation:
Highest grade completed:	Highest grade completed:
Parental Marital Status: Never Married ( ), Married ( ), Remarried ( ), Divorced ( ) Separated ( ), Widowed ( ), Partnered/Other ( ), # of Marriage ( )	
If applicable, your age at time of parental separation, divorce, or death:	

1. How do you get along with your <u>father</u>? Poor ____, Average ____, Great ____

2. Is there anything about your relationship with your <u>father</u> that would be helpful to know in counseling?_____
3. How do you get along with your <u>mother</u>? Poor ____, Average ____, Great ____
4. Is there anything about your relationship with your <u>mother</u> that would be helpful to know in counseling?_____

Parent's history of learning, emotional, or behavioral problem: Yes ( ), No ( ) if yes, mother____, father_____, or both_____, please explain:
Parent's history of alcohol/drug/substance abuse: Yes ( ), No ( ) if yes, mother____, father_____, or both_____, please explain:
Parent's history of domestic violence: Yes ( ), No ( ) if yes, mother____, father_____, or both_____, please explain:
Parent's history of criminal activity: Yes ( ), No ( ) if yes, mother____, father_____, or both_____, please explain:
Parent's history of sexual/verbal/mental abuse: Yes ( ), No ( ) if yes, mother____, father_____, or both_____, please explain:

<u>Siblings</u>

1. Number of siblings:_____
2. Your birth order: Youngest_____, Middle_____, Oldest_____, Other_____
3. Names, ages, and how do you get along?
   _____ _____ Poor ____, Average ____, Great ____
   _____ _____ Poor ____, Average ____, Great ____
   _____ _____ Poor ____, Average ____, Great ____

<u>Self-Description</u>

Please give a word-picture of yourself as you would be described by:

1. Spouse or significant other:_____
2. Your best friend:_____
3. Someone who dislikes you:_____
4. Self-description:_____

Medical Information

1. Primary Care Physician: Name:_____
   Address:_____ Phone:_____
2. When was your last physical?_____
3. Are you aware of any significant information about your birth or development?
   _____
4. Present or Chronic Illnesses:_____
5. Current Medication (Indicate dosage and prescribing physician)_____
   _____
6. Past Psychiatric Medications:
   <u>Medication</u> <u>Dosage</u> <u>Response</u> <u>How long</u> <u>Why stopped</u>
   _____
   _____
7. Please indicate with a "X" mark if your <u>childhood/adolescent/young adult</u> history includes any of the following:

	Birth complications		Attention difficulties

	Major childhood illnesses		Victim of sexual abuse
	Major childhood injuries		Victim of physical abuse
	Major childhood stresses		Victim of parental domestic violence
	Head injury (major or minor)		Difficult family situation
	Seizures		Problematic childhood/adolescence
	Substance or alcohol abuse		Childhood behavior problems
	Childhood anxiety		Childhood legal problems
	Childhood depression		Learning disabilities
	allergies		Parental separation/divorce
	Separation from parents		Adoption

8. Please provide details concerning checked items:

_____
_____
_____
_____

9. Number of hours of sleep per night_____
10. Frequent waking or nightmares?___, if so, specify (frequency, etc):_____
    _____
11. Do you have concerns about your weight?_____
12. What percentage of food is home cooked?_____
13. Describe any unusual eating habits (picky eater, eating nonedible items, etc.)
    _____

Educational/Occupational Information

Education

1. Highest grade completed in school, including degrees earned (indicate subject major).
   _____
2. Describe your academic strengths.
   _____
3. Describe any academic difficulties.
   _____
4. Compared to other students you went to school with as a child, how would you rate your overall intelligence level?
   Below average____, Average____, Average____, Gifted____

Occupation

1. Describe your current employment position:_____
   Number of years_____
2. List other positions you have held:
   Type of Job Years
   _____
   _____
   _____
3. Are you satisfied with your present work? Yes_____, No_____
4. If yes, in what ways are you **satisfied**?_____
5. If no, in what ways are you **dissatisfied**?_____
6. Any conflicts with co-workers or supervisors?_____

Mental health history

1. Have you ever received counseling treatment in the past? Yes_____, No_____ If yes, please list:
   Dates of Care Provider Purpose/Outcome
   _____ _____ _____
   _____ _____ _____
2. Have you ever been hospitalized for a mental health condition? Yes__, No__If yes, please describe when, where and why: _____
   _____
3. Are you having thoughts of wanting to harm yourself? Yes_____, No_____
   If yes, intensity of thoughts is: Mild_____, Moderate_____, Severe _____
   If yes, do you have a plan or intend to harm yourself? Yes_____, No_____
4. Have you ever thought about or attempted to harm yourself in any way? Yes_____, No_____
   If yes, intensity of thoughts is: Mild_____, Moderate_____, Severe _____
   Please explain (when):_____
   _____
5. Have you ever thought about or inflicted physical violence on another person? Yes____, No____
   If yes, intensity of thoughts is: Mild_____, Moderate_____, Severe _____
   Please explain: _____
6. List any family history of mental health problems. Please list the relation to you:
   _____
7. Are you currently taking any psychiatric medications? Yes___, No___ If yes, please list medication,dosage and prescriber: _____
8. Any psychiatric medication taken in the past? (please list) _____
9. Are you in a relationship in which you have been hurt or threatened? Yes_____, No_____
10. Legal issues due to domestic violence for you or partner? Yes_____, No_____

Drug & Alcohol Use

1. Do you think drug or alcohol use contributes to your current problems in life? Yes_____, No____
   If yes, please explain current substance use:_____
2. Have you ever felt the need to cut down on your drinking or drugging? Yes_____, No_____
3. Have you ever been annoyed by someone criticizing your drinking or drugging? Yes____,No____
4. Have you ever felt guilty about your drinking? Yes_____, No_____
5. Have you ever had a drink first thing in the morning to steady your nerves Yes_____, No_____
   or for a hangover (eye-opener) Yes_____, No_____?
6. Do you think you have a current problem with drugs or alcohol? Yes_____, No_____
7. Do you have a past history of an alcohol or drug problem? Yes_____, No_____
8. Have you ever been in drug/alcohol treatment? Yes_____, No_____
   If yes, please explain: _____

Present Concerns

Emotional

	Excessive crying		Gives up when challenged
	Overreacts to normal situations with excessive anger, fear, sadness, etc		Appears depressed
	Feeling guilty or shameful		Feeling sadness depression or suicidal urges

			related to grief.
	Disturbing memories (past abuse, neglect or other traumatic experience)		Feeling sadness depression or suicidal urges **NOT related to grief.**
	Excessive fear and often worried		Appears excessively angry
	Unexplained fears and anxiety		Mood swings
	Specific fears		Panic attacks
	Frequent nightmares or bad dreams		Low self-esteem
	Excessive happy		Major weight loss or unexplained weight loss
	Excessive anger or aggressive behaviors		Lacking interest in things once enjoyed
	Loss of energy		Recent changes in sleeping and eating patterns
	Feeing fatigue		Heard voices when no one was around
	Eating too much or major weight gain		Thoughts of harming or killing myself
	Excessive complaints about aches and pains		Suicidal attempts/self harm/cutting
	Feel inferior, not good enough		Unable to relax
	Feeling overwhelmed by life		Previous suicidal thoughts & attempts

Behavioral

	Taken advantage of		Communication difficulties
	Withdrawn		Hyperactive
	Frequently fights or arguments with others		Slapping, hitting, shoving
	Frequent fights or arguments with family members		Sleep problem (nightmares, night-terror, sleeping too much or too little, etc.)
	Impulsive		Overreacting to things
	Alcohol and/or drug use		Difficulty focusing
	Accident—prone		Poorly organized
	Temper outbursts		Experiences difficulty starting tasks
	Serious over-eating or under-eating		Acts before thinking
	Daydreaming		Can't sit still
	Back pain		Experiences difficulty planning
	Headaches		Difficulty making decisions
	Digestive problems		Rapid heart beat/pounding heart
	Stomach pain		Abuse (physical, emotional, sexual)
	Health concerns (physical complaints and/or medical problems)		Serious depression (Listlessness, loneliness, withdrawal, or difficulty making friends)
	Chest pain		Troubled with law
	Relationship problems		Not completing work/tasks
	Housing problems		Ran away
	Financial problems		People are following me
	Attention problems/Poor concentration		People are watching me
	Adjustment to life changes (changing schools, parent's divorcing, moving, etc.)		A need to wash, count, or perform certain rituals many times per day to avoid unsubstantiated danger
	Engages in risky behaviors		Inappropriate sexual comments and/or behaviors

Thank you for taking the time to complete this questionnaire thoroughly!