

**♥ 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)

1. Describe your major concerns, including duration of those concerns and any previous attempts to resolve them.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate with “X” mark how severe your concerns are at this point in time:

\_\_\_\_\_ Mildly upsetting

\_\_\_\_\_ Moderately severe

\_\_\_\_\_ Very severe

\_\_\_\_\_ Extremely severe

\_\_\_\_\_ Incapacitating

1. How often does the problem behavior occur? (5x/day, 2x/week, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long have you had this problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How is this problem affecting you at home? At work? In relationship?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What goals do you have for your treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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10. Anything else you think I need to know?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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11. Please describe your strengths

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**<Background Information>**

**Family History**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Date of Birth | Age | Gender | Relationship |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. 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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. How long have you lived at the current address?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please describe any religious or cultural beliefs you would like incorporated into your treatment. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Marital Status: Single\_\_, Engaged\_\_, Married\_\_, Re-married\_\_,

 Separated\_\_, Divorce\_\_, Widowed\_\_, Partnered/Other\_\_

1. 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)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are there any fearful of distressing experiences regarding your family life which stand out in your mind which were not previously mentioned? (briefly describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are there other family members that you are close with?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. 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 father? Poor \_\_\_\_, Average \_\_\_\_, Great \_\_\_\_
2. Is there anything about your relationship with your father that would be helpful to know in counseling?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How do you get along with your mother? Poor \_\_\_\_, Average \_\_\_\_, Great \_\_\_\_
4. Is there anything about your relationship with your mother 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: |

**Siblings**

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 \_\_\_\_

**Self-Description**

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When was your last physical?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you aware of any significant information about your birth or development? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Present or Chronic Illnesses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Current Medication (Indicate dosage and prescribing physician)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Past Psychiatric Medications:

Medication Dosage Response How long Why stopped

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please indicate with a “X” mark if your childhood/adolescent/young adult 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 |

1. Please provide details concerning checked items:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Number of hours of sleep per night\_\_\_\_\_\_\_\_
2. Frequent waking or nightmares?\_\_\_, if so, specify (frequency, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have concerns about your weight?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What percentage of food is home cooked?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. 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).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Describe your academic strengths.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Describe any academic difficulties.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List other positions you have held:

Type of Job Years

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Are you satisfied with your present work? Yes\_\_\_\_\_, No\_\_\_\_\_
2. If yes, in what ways are you **satisfied**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. If no, in what ways are you **dissatisfied**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. 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

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been hospitalized for a mental health condition? Yes\_\_, No\_\_If yes, please describe when, where and why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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\_\_\_\_\_

1. 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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List any family history of mental health problems. Please list the relation to you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently taking any psychiatric medications? Yes\_\_\_, No\_\_\_ If yes, please list medication,dosage and prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Any psychiatric medication taken in the past? (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you in a relationship in which you have been hurt or threatened? Yes\_\_\_\_\_, No\_\_\_\_\_
4. 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever felt the need to cut down on your drinking or drugging? Yes\_\_\_\_\_, No\_\_\_\_\_
2. Have you ever been annoyed by someone criticizing your drinking or drugging? Yes\_\_\_\_,No\_\_\_\_
3. Have you ever felt guilty about your drinking? Yes\_\_\_\_\_, No\_\_\_\_\_
4. 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\_\_\_\_\_?

1. Do you think you have a current problem with drugs or alcohol? Yes\_\_\_\_\_, No\_\_\_\_\_
2. Do you have a past history of an alcohol or drug problem? Yes\_\_\_\_\_, No\_\_\_\_\_
3. 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!**



HopeSpring Child & Family Clinic, LLC

703-259-5617 • Fax: 703-552-2037

3915 Old Lee Hwy #23A Fairfax, VA 22030

Info@hopespringchildandfamily.com • [www.hopespringchildandfamily.com](http://www.hopespringchildandfamily.com)