Background Information Questionnaire

Instruction: This questionnaire is designed to help you assist us in collecting information to provided the most accurate assessment. This information helps us in this effort. By providing this questionnaire prior to the session, you have the opportunity to have family members assist you with information you may not remember. Please complete as much of the questionnaire as possible. If you have problems with different sections, we can go over this information in the evaluation session. Thank you!

General Information:

Name:____ Birth date:______________________________

Social Security Number:_________________________________Age:_________ Marital Status:_____________

Address:____

Phone Number:_________________________________Ethnic Background:_____________________________

Living Arrangements: ☐ Alone ☐ With Spouse ☐ With Parents ☐ With Friends ☐ In Group Home

☐ Other (specify:____)

Name of individuals who completed this questionnaire and/or provided information needed to filling out the questionnaire if other than yourself

Who referred you?____

Problems you are currently experiencing & when you started having the problem:

Problem	Onset

Please state any specific questions you or the referring source has which need to be answered by this evaluation:

Background History:

At what point did you begin to experience problems related to your current concern? Please note any events or changes that occurred.____

What emotional or psychological problems have you had in your past?_____________________________________

____

What psychotropic medications have you taken in the past & for what condition?____________________________

____

Have you ever been hospitalized for mental or emotional problems (If yes, state where and when.)?____________________

____

List any other counseling you or your family has had in the past?

How to you feel about seeking and obtaining counseling or therapy?

What have you found in the past that has helped you cope with stress and/or depression?

Have you had psychological testing in the past? Please state where and when

Family Psychiatric/Psychological History

Please check any family history of emotional problems or mental disorders (both diagnosed and suspected):

✘		Additional notes:
	depression	
	mood swings	
	explosive anger	
	anxiety problems	
	obsessive-compulsive disorder	
	learning disorders	
	schizophrenia	
	attention-deficit hyperactivity disorder	
	bipolar disorder	
	paranoia	

	seizures	
	neurologic disorders	
	insomnia	
	eating disorder	
	PTSD	
	Alzheimer's Disease	
	Other:	

Birth History:

Where were you born?____

Did your mother take any medications during pregnancy?

During pregnancy, did your mother use any of these? ☐ alcohol ☐ marijuana ☐ amphetamines ☐ tobacco ☐ other

Were there any problems during pregnancy?

Were there any problems with the delivery?

Birth Weight:_________________ Was the birth premature?

Were there any birth defects or complications after delivery

Developmental History:

Briefly describe your childhood years? (Who you lived with, children in the home, deaths, etc.)

Describe what type of child you were when you were growing up:

What forms of discipline were used in the family you grew up in?

As a child, how did you cope with conflict or stressful situations?

Were you ever abused as a child?

Please list family members (including yourself), and fill in current age, and strengths.

Family Member		Current Age	Strengths	Your Relationship With
YOU				
YOUR FATHER				
YOUR MOTHER				
BROTHERS & SISTERS				

Changes/Moves During Childhood Years:

Please note any divorces, remarriages, or other major changes in your family when you were a child?

Parent's Employment during your childhood:

Father's Position	Employer	Length of Employment
Mother's Position	Employer	Length of Employment

When you were growing up, what types of family problems were there?

Peer Group/s: Childhood:

Current:

Hobbies/Activities: Past:

Current:

Financial issues: Past:

Current:

Your Religion/Belief System:

List dates of marriages, separations, and divorces:

1st marriage:____

separation:____

divorce:______________________________

2nd marriage:______________________________
separation:______________________________
divorce:______________________________

3rd marriage:______________________________
separation:______________________________
divorce:______________________________

4th marriage:______________________________
separation:______________________________
divorce:______________________________

How many children do you have? (Please list first names, ages, and if they currently live with you.)

Child's Name	Age	Living Situation

How many grandchildren do you have?______________________________

How would you describe your cultural orientation? Please explain

What do you see as being the strongest symbols and/or rituals which have meaning to you?

What memories from your childhood do you find strength in?

Education:

Highest Grade Completed:______________________________ Average GPA:______________________________

Name of Schools Attended:

Favorite Subject/s:______________________________

Least Favorite Subject/s:______________________________

Extracurricular activities (e.g., sports, clubs, etc.).______________________________

Current Career Goals

	GRADE (Year In School)											
	1	2	3	4	5	6	7	8	9	10	11	12
AVERAGE GPA												

School Performance

✘	**Problems**
	truancy
	absences because of illness
	absences (not related to illness)
	fights with student
	oppositional behavior towards teachers
	drug and/or alcohol use
	acting out behavior
	difficulty learning
	emotional problems
	social withdrawal
	suicidal thoughts or gestures
	Other (specify):

✘	**Extracurricular Activities**
	School Club:
	Track
	Basketball
	Cheerleading
	Baseball
	Football
	Soccer
	Student Assistant

	D/A Prevention Activities
	Other (specify):

Classes Where You Had Problems

Classes of You Enjoyed

History of Remedial Services (tutoring, speech therapy, etc.):

Employment: (*Please be complete or attach resume*).

When did you last work?____

In the Table below, list your past employment history:

Position	Employer	Length of Employment	Reason for Leaving	Problems Experienced

Position	Employer	Length of Employment	Reason for Leaving	Problems Experienced

Current Career Goals:____

____

What problems are you likely to have in obtaining and maintaining employment?___________________________

____

____

When in your last job, what was your energy level? ☐ adequate ☐ vigorous ☐ driven ☐ low ☐ easily fatigued

Do you have any difficulty concentrating while at work? ☐ yes ☐ no ☐ occasionally

What type of mistakes have you made while employed?_______________________________________

____

____

How would other individuals describe your level of productivity when working?___________________________

____

When employed, describe your attendance and punctuality?____________________________________

____

What were the primary reasons for absences?____

____

Describe your communication and interpersonal skills with supervisors and coworkers?____________________

____

What is your accident history?____

____

____

What are your greatest talents that you bring to the work place?_______________________________

____

What types of jobs would you like to be doing over the next 20 years? (If applicable)_____________________

____

Are you able to manage your time and energy well to complete a job?___________________________

____

What are your greatest difficulties within the workplace?____________________________________

____

Military Service: Dates of Service:____

Rank:______________________________Function:______________________________

Discharge Type:____

NOTES ON MILITARY SERVICE:

Physical, Medical, & Nutritional

Who is your physician (include address & telephone number)?____
____

List any other physicians or health professionals that you currently see or have seen in the last year:

When was your last medical examination?___________________ How frequently do you see your physician?____________

Current medical issues:

Current medications you are taking:

Current herbal medications, supplements, and/or vitamins you are taking:

Chemical sensitivities or reaction to medications:

-

Have you ever had prolonged use or exposure to solvents/toxic chemicals? ☐ Yes ☐ No If yes, please list:

Please check medical problems you have had in the past:

✘	NEXT TO THE ILLNESS, PROVIDE ANY ADDITIONAL INFORMATION.
	Measles
	German measles
	Mumps
	Chicken pox
	Whooping cough
	Diphtheria
	Scarlet fever
	Rheumatic fever
	Malaria
	Headaches
	Migraines
	Extreme tiredness/ weakness
	High fever
	Meningitis
	Encephalitis
	Epilepsy (seizures)
	Coma
	Tuberculosis
	Polio
	Fainting spells
	High blood pressure
	Stroke
	Chest pain
	Heart disease
	Heart attack

✘	NEXT TO THE ILLNESS, PROVIDE ANY ADDITIONAL INFORMATION.
	Bone or joint disease
	Fibromyalgia
	Muscle disease
	Bleeding problems
	Anemia
	Syphilis
	Chlamydia
	Herpes
	Other STD
	HIV infection
	Sunstroke
	Near drowning
	Altitude sickness
	Electrical shock
	Injury to the head
	Tumor
	Cancer
	Paralysis
	Eye or vision problems
	Ear or hearing problems
	Loss of sense of touch
	Tingling/ numbness feelings
	Loss of sense of smell
	Loss of sense of taste
	Difficulty with balance
	Eczema or hives
	Allergies
	Pulmonary (lung) disease
	Jaundice or hepatitis
	Kidney problems
	Chronic Pain
	Dialysis
	Parkinson’s disease
	Huntington’s disease

✘	NEXT TO THE ILLNESS, PROVIDE ANY ADDITIONAL INFORMATION.
	Multiple sclerosis
	Lupus
	Electric shock therapy
	Lead poisoning
	Exposure to pesticides
	Carbon monoxide poisoning
	Nutritional deficiencies
	Alcoholism
	Broken bones
	Hospitalizations
	Operations
	Hypothyroidism
	Hyperthyroidism
	Diabetes
	Hypoglycemia
	Endocrine disorders
	Gynecological problems
	Miscarriages
	Menstrual Irregularity
	Gallstones
	Gallbladder Problems
	Back injuries
	Other (specify):____________

Medication History

Please complete the following form as completely as you can (use additional sheet if necessary).

Medications, Dosage & Your Age at the time you were prescribed the medication.	Condition Treated	Effectiveness (very, somewhat, not at all)	Negative Side Effects

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Head Injuries: Please list head injuries you have had, and provide details if possible.

DATE	EVENT	COMMENTS

Family history of medical problems:

How much sleep do you get per night?______________________ Is it restful sleep?____________________________

Medication/s used for sleep:____

Sleep Questionnaire (Please check the items that are current problems)

✘	difficulty falling to sleep
	difficulty maintaining sleep
	fatigue on awakening
	pain and stiffness on awakening
	excessive sleepiness during the day
	vigorous exercise in the evening
	excessive fluid after dinner
	excessive caffeine
	excessive alcohol
	eating before bedtime
	heavy foods in the evening
	watching television before bedtime
	nocturia (the need to urinate at night)
	excessive noise
	uncomfortable mattress

	poorly controlled temperature
	sleep medication
	restlessness
	snoring
	pets in the bedroom or on the bed
	excessive stress
	walking in one's sleep
	sleep eating
	nightmares
	night terrors
	night sweats
	sleep apnea
	uses C-PAP
	uses Bi-PAP
	restless legs while sleeping
	difficulty breathing while sleeping
	excessive nasal congestion at night
	bruxism (grinding teeth)

Weight History (list history over the last ten years).

YEAR ➜										
Weight (lbs)										

Current Weight:______________________________Current Height:____

Highest Weight:_________________________________At what age?____

Lowest Weight:_________________________________At what age?____

Weight Change During Menses:____

Described what other methods have been attempted to control or alter weight in the past (use additional paper:

What recommendations have your health care providers given you and what problems have you had in complying with the recommendations?

Are there seasonal or other changes in your eating pattens? Please describe.

Do you eat breakfast?
If yes, type of foods?

Do you eat lunch?
If yes, type of foods?

Do you eat dinner?
If yes, type of foods?

What food allergies do you have?

Have you recently lost or gained weight? ☐ Yes ☐ No If yes, indicate the weight you were, the weight you are now, and the length of time the weight change occur?____

Please check the types of ways that you have attempted to lose weight.

☐ fasting ☐ exercise ☐ dieting (specify types of diets)____

Have you ever vomited after a meal to get rid of the food you just ate? ☐ Yes ☐ No If Yes, specify period of time and frequency.

____

Have you ever abused laxatives to lose weight or get rid of the food you just ate? ☐ Yes ☐ No If Yes, specify period of

time and frequency.____

Current and Past Weight Loss Attempts

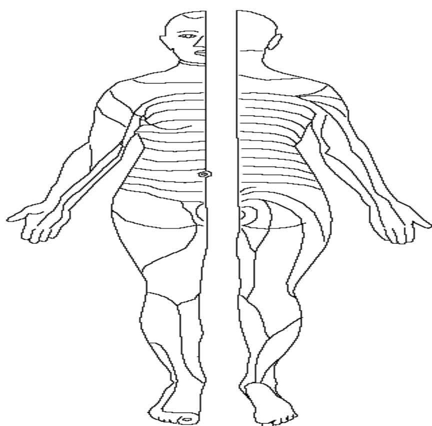
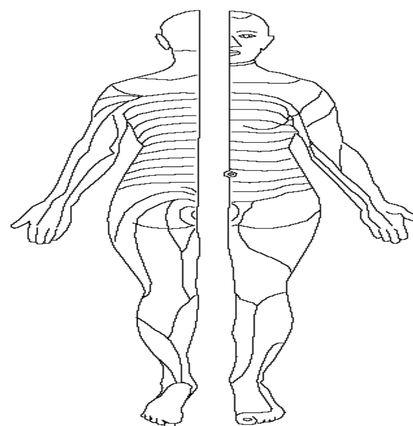
How successful you were with each method.

Do you feel that you are fat? ☐ Yes ☐ No Do you feel that you have an eating disorder? ☐ Yes ☐ No

Have you ever been treated for an eating disorder? ☐ Yes ☐ No If yes, described:_____________________________

How much water do you drink per day? _____________How much carbonated beverages do you drink per day? ________

PAIN: If you suffer from pain, please note type, location and how often you experience the pain in the space below.

How well do you tolerate pain and what helps?
 

Alcohol/Drug History:

In the table below, please list drugs you have taken (Please use back of form if necessary.). Please complete all columns.

Drug	Admission (oral, intravenous, etc.)	First Use	Last Use	Frequency	Heaviest Use	Do you feel that you are addicted?
Alcohol						
Marijuana						
Amphetamines						
Tobacco						
Cocaine						
Heroin						
Opiates						
Mushroom						
LSD						
Other:						
Other:						
Other:						
Other:						

Have you had: ☐ blackouts ☐ passed out ☐ medical problems related to alcohol or drug use ☐ hangovers
☐ any legal problems related to alcohol/drug use ☐ family problems

If you use alcohol or other drugs, please describe below the reasons that you drink/use:________________________________

____

____

Have you attended AA or any other 12 Step Program in the past? Please explain.__________________________________

____

List any Alcohol/Drug Treatment including DUII programs you have attended (please note date):

Is there any family history of problems with alcohol or drugs? Please describe

If recovering, please describe your recovery program and how you stay in recovery:

Do you use tobacco? ☐ yes ☐ no If yes, please how and quantity per day.______________________________________

Legal History:

Are you currently involved with litigation or other court involvement? ☐ Yes ☐ No If YES, explain:____________________

Do you foresee any reason that the psychological report will be requested by the court?________________

Please list any criminal charges, divorces, bankruptcies, or other legal involvements.

DATE	EVENT	COMMENTS

DAILY ACTIVITIES QUESTIONNAIRE

Current living situation: ☐ homeless ☐ camping ☐ living in trailer ☐ living in mobile home ☐ living with parents ☐ living with friends ☐ living in an apartment ☐ living in house Check the one that is appropriate: ☐ renting ☐ staying without rent ☐ own home ☐ other:
What is your typical day like? Note the time you wake up, activities throughout the day and the time you go to bed. Please note any problems that you have. Wake up between: Go to bed: Fall asleep:
Do you socialize? Note with whom and how often? Note if socializing is a problem.

Current Level of Function:

Do you have trouble with **(note any help you require):**	✔	Explanation
handling finances or checkbook		
spending more than you should		

Do you have trouble with **(note any help you require)**:	✔	Explanation
getting out of bed		
showering or bathing		
taking care of personal hygiene and grooming		
dressing		
doing laundry		
washing dishes		
vacuuming		
keeping things picked up		
preparing simple meals and snacks		
preparing meals from scratch		
driving		
obtaining transportation		
using public transportation		
leaving the house		
traveling in unfamiliar places		
shopping		

Do you have trouble with **(note any help you require)**:	✔	Explanation
communicating with family		
communicating with friends		
communicating with strangers		
communicating with individuals in authority		
being in a crowded location with other people		
remembering how to do daily tasks		
working outside		
using your hands or holding on to items		
maintaining attention		
enjoying leisure activities		
motivating self to do activities		
having difficulty ending an activity to go to bed		
getting regular sleep		

Note how often you do the following	
brush teeth	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
bathe	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
change clothes	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
wash hands	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever

dust	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
vacuum	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
wash dishes	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
do laundry	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
work in the yard	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
visit with friends	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
do something fun	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
go shopping	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
drive a car	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever
take a walk	☐ daily ☐ every other day ☐ 2 to 3 times per week ☐ weekly ☐ every 2 weeks ☐ monthly ☐ hardly ever

Source of income: ☐ Self ☐ Spouse ☐ Parents ☐ Private Insurance ☐ Public assistance ☐ Children ☐ Other

Have you ever gambled more than you had planned? _______Do you or others feel you have a gambling problem?_______

Out of one week, how many days do you feel that your function is poor?______________________________

Amount of time spent per day watching television:____

Amount of time spent per day doing housework:____

Amount of time spent per day visiting or socializing with others:____

State any limits you feel impact your ability to function and maintain employment

Do you have a driver's license? ☐ Yes ☐ No If Yes, were there any special accommodations made (such as having the test given orally) which were made for you to take the test. Please explain:

How many times did you have to take the written test before passing?