

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

- | | |
|---|---|
| <input type="checkbox"/> depression | <input type="checkbox"/> paranoia |
| <input type="checkbox"/> mood swings | <input type="checkbox"/> seizures |
| <input type="checkbox"/> explosive anger | <input type="checkbox"/> neurologic disorders |
| <input type="checkbox"/> anxiety problems | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> obsessive-compulsive disorder | <input type="checkbox"/> eating disorder |
| <input type="checkbox"/> learning disorders | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> schizophrenia | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> attention-deficit hyperactivity disorder | <input type="checkbox"/> Other: |
| <input type="checkbox"/> bipolar disorder | |

Birth History:

Where were you born? _____

Did your mother take any medications during pregnancy? Yes No If YES, explain: _____

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

Were there any problems during pregnancy? Yes No If YES, explain: _____

Were there any problems with the delivery? Yes No If YES, explain: _____

Birth Weight: _____ Was the birth premature? Yes No If YES, how many weeks: _____

Were there any birth defects or complications after delivery? Yes No

If YES, explain: _____

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?

Emotionally: Yes No If YES, by whom: _____

Verbally: Yes No If YES, by whom: _____

Physically: Yes No If YES, by whom: _____

Sexually: Yes No If YES, by whom: _____

Please check any of the following developmental, behavioral or emotional issues you experienced **as a child**:

- | | |
|---|--|
| <input type="checkbox"/> Poor reading comprehension | <input type="checkbox"/> Difficulty reading aloud |
| <input type="checkbox"/> Difficulty with phonics | <input type="checkbox"/> Poor handwriting |
| <input type="checkbox"/> Reading problems | <input type="checkbox"/> Difficulty with math computational skills |

- Difficulty with spelling
- Difficulty working independently
- Difficulties with verbal expression
- Difficulties with written expression
- Difficulties with grammatical skills
- Poor organizational skills
- Poor planning skills
- Incomplete projects
- Difficulty following instructions
- Chronic procrastination
- Disturbs other students
- Negative attitude toward school
- Unwillingness to complete homework accurately
- Difficulty keeping up with class
- Poor coordination
- Poor balance
- Right/Left Confusion
- Poor articulation or speech problems
- Difficulty discriminating different sounds
- Difficulty associating sounds with the source of the sound
- Difficulty sequencing symbols (e.g., letters, numbers)
- Difficulty putting events in sequence or order
- Difficulty making comparisons
- Difficulty predicting the outcome of a story or event
- Difficulty differentiating between fact and fiction
- Difficulty remembering and expressing facts
- Difficulty relating to cause and effect
- Excessive talking
- Talking at inappropriate times
- Difficulty imitating sounds
- Difficulty remembering words (but can repeat them)
- Difficulty naming common objects
- Visual Impairment (Inability to see with acuity)

- Visual tracking (loss of place when reading)
- Withdrawal or social isolation
- Excessive sensitivity to failure
- Resistance to accepting help
- Short attention span
- Impulsive
- Fidgety
- Distractible
- Accident-prone
- Forgetful
- Daydreams
- Unpredictable
- Impatience
- Low tolerance to frustration
- Difficulty accepting responsibility
- Low self-confidence
- Tantrums
- Superstitious activities
- Extreme mood change
- Excessive fantasizing
- Phobic (fearful) reactions
- Suicidal tendencies
- Bed-wetting (in older children)
- Incontinence (in older children)
- Repeated stomachaches
- Sleep disturbances
- Chronic lying
- Depression
- Attempts to control self or others
- Unwillingness to communicate
- Substance abuse
- Explosive anger
- Chronic bullying

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:

marriages: _____

separations: _____

divorces: _____

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 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

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

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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: _____

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:

- 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
- 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
- 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

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

DATE	EVENT	COMMENTS

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)

- | | | |
|--|--|--|
| <input type="checkbox"/> difficulty falling to sleep | <input type="checkbox"/> watching television before bedtime | <input type="checkbox"/> sleep eating |
| <input type="checkbox"/> difficulty maintaining sleep | <input type="checkbox"/> nocturia (the need to urinate at night) | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> fatigue on awakening | <input type="checkbox"/> excessive noise | <input type="checkbox"/> night terrors |
| <input type="checkbox"/> pain and stiffness on awakening | <input type="checkbox"/> uncomfortable mattress | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> excessive sleepiness during the day | <input type="checkbox"/> poorly controlled temperature | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> vigorous exercise in the evening | <input type="checkbox"/> sleep medication | <input type="checkbox"/> uses C-PAP |
| <input type="checkbox"/> excessive fluid after dinner | <input type="checkbox"/> restlessness | <input type="checkbox"/> uses Bi-PAP |
| <input type="checkbox"/> excessive caffeine | <input type="checkbox"/> snoring | <input type="checkbox"/> restless legs while sleeping |
| <input type="checkbox"/> excessive alcohol | <input type="checkbox"/> pets in the bedroom or on the bed | <input type="checkbox"/> difficulty breathing while sleeping |
| <input type="checkbox"/> eating before bedtime | <input type="checkbox"/> excessive stress | <input type="checkbox"/> excessive nasal congestion at night |
| <input type="checkbox"/> heavy foods in the evening | <input type="checkbox"/> walking in one's sleep | <input type="checkbox"/> 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 patterns? Please describe. _____

Do you eat breakfast? Yes, daily. Sometimes No

If yes, type of foods? _____

Do you eat lunch? Yes, daily. Sometimes No

If yes, type of foods? _____

Do you eat dinner? Yes, daily. Sometimes No

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.

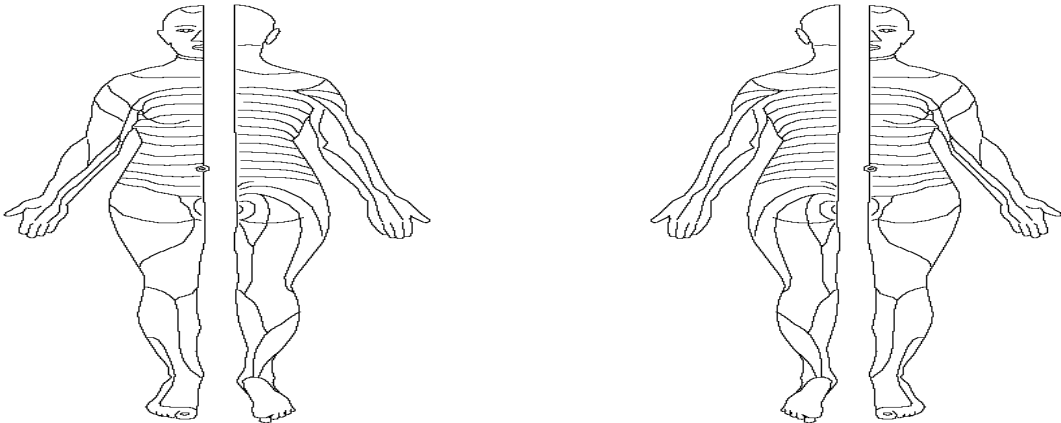
Do you feel that you are fat? Yes No

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:						

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

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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 sleep between:

Do you socialize? Note with whom and how often? Note if socializing is a problem.

Can you dress without help? Explain.

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Current Level of Function:

<i>Do you have trouble with</i> (note any help you require):	✓	Explanation
handling finances or checkbook	<input type="checkbox"/>	
spending more than you should	<input type="checkbox"/>	
getting out of bed	<input type="checkbox"/>	
showering or bathing	<input type="checkbox"/>	
taking care of personal hygiene and grooming	<input type="checkbox"/>	
dressing	<input type="checkbox"/>	

<i>Do you have trouble with</i> (note any help you require):	✓	Explanation
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		
communicating with family		
communicating with friends		
communicating with strangers		
communicating with individuals in authority		

<i>Do you have trouble with</i> (note any help you require):	✓	Explanation
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	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
bathe	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
change clothes	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
wash hands	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
dust	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
vacuum	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
wash dishes	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
do laundry	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
work in the yard	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
visit with friends	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
do something fun	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
go shopping	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever

drive a car	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> hardly ever
take a walk	<input type="checkbox"/> daily <input type="checkbox"/> every other day <input type="checkbox"/> 2 to 3 times per week <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> monthly <input type="checkbox"/> 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? _____