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):

- ☐ 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? ☐ 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**:

- ☐ Poor reading comprehension
- ☐ Difficulty with phonics
- ☐ Reading problems
- ☐ Difficulty reading aloud
- ☐ Poor handwriting
- ☐ 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

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

Current	Past	Classes Where Child Has Problems	Current	Past	Classes of Special Interest to Child
☐	☐	English	☐	☐	English
☐	☐	Science	☐	☐	Science
☐	☐	Social Studies	☐	☐	Social Studies
☐	☐	Music	☐	☐	Music
☐	☐	Art	☐	☐	Art
☐	☐	Math	☐	☐	Math
☐	☐	Physical Education	☐	☐	Physical Education
☐	☐	Health	☐	☐	Health
☐	☐	Other (specify):_____	☐	☐	Other (specify):_____

Current	Past	Extracurricular Activities	Current	Past	Extracurricular Activities
☐	☐	School Club:_____	☐	☐	Football
☐	☐	Track	☐	☐	Soccer
☐	☐	Basketball	☐	☐	Student Assistant
☐	☐	Cheerleading	☐	☐	D/A Prevention Activities
☐	☐	Baseball	☐	☐	Other (specify):_____

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:_____

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)

- ☐ 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? ☐ 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.

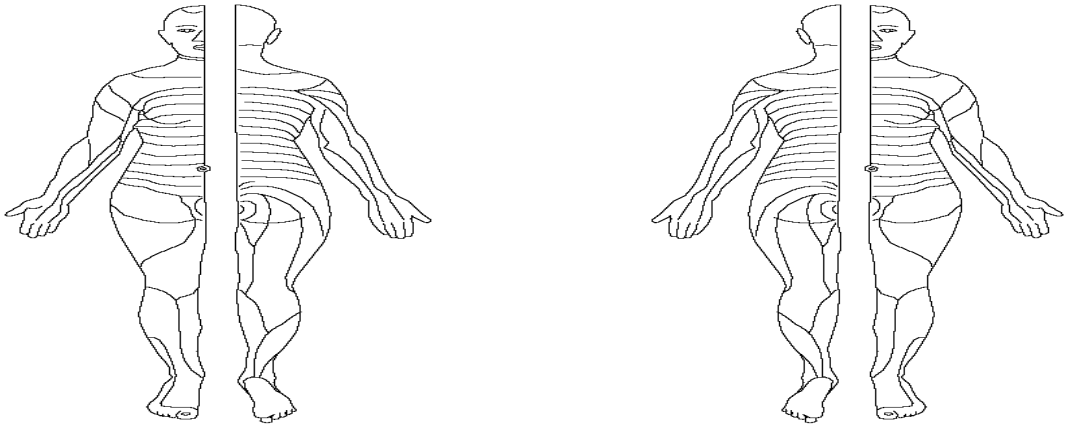
Do you feel that you are fat? ☐ Yes ☐ No Do you feel that you have an eating disorder? ☐ Yes ☐ No

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

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.

Current Level of Function:

Do you have trouble with **(note any help you require)***:*	✔	Explanation
handling finances or checkbook		
spending more than you should		
getting out of bed		
showering or bathing		
taking care of personal hygiene and grooming		
dressing		

Do you have trouble with **(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		

Do you have trouble with **(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	☐ 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?_____