ADULT BACKGROUND AND HISTORY QUESTIONNAIRE

Name_____ Today's Date_____

Education

What is the highest grade/level of school you completed?_____

Any history of academic/learning problems? YES NO
If yes, please explain_____
_____

Employment

Are you currently employed? YES NO
Current position?_____
Are you experiencing any work-related problems at this time? YES NO
If yes, please explain:_____
_____
_____

Relationship Status

____ Single
____ Married
____ In a committed relationship
____ Separated
____ Divorced

Living Situation

Who lives in your home?

Name Relationship Age
_____
_____
_____
_____
_____
_____
_____

Medical History

Name and address of primary care physician:
_____
_____
_____

Have you experienced any medical problems?
Please specify:

_____
_____
_____
_____
_____

Have you had a significant appetite change in the last month? YES NO
Comments:_____

Have you had a significant change in sleep patterns in the last month?
YES NO
Comments:_____

Behavioral/Emotional Health History

Please indicate any past or present behavioral or emotional concerns:

	Past	Present
Inattention	____	____
Hyperactivity	____	____
Fears/Phobias	____	____
Sad/Depressed mood	____	____
Eating concerns – strict dieting	____	____
Eating concerns – overeating	____	____
Eating concerns – binging and purging	____	____
Eating concerns – excessive exercise	____	____
Learning problems	____	____
Difficulty getting along with others	____	____
Social skills problems	____	____
Suicidal thoughts	____	____
Suicide attempts	____	____
Cutting or mutilating body	____	____
Obsessive thoughts and/or actions	____	____
Excessive energy/mania	____	____
Decreased energy	____	____

Other concerns (please specify) _____

Have you had previous outpatient psychological treatment? YES NO

Name of therapist Dates of treatment Reason for treatment

_____
_____
_____
_____

Have you had previous inpatient psychological treatment? YES NO

Name of program/facility Dates of treatment Reason for treatment

_____
_____

Have you taken any medication in the past to address emotional, behavioral or academic problems? If so please specify:

Medication Dosage Reason

_____
_____
_____
_____

Are you currently taking any medication (prescription, over-the-counter, vitamins, herbs, or supplements) for emotional, behavioral, academic, or medical reasons?

Medication Dosage Reason

_____
_____
_____
_____
_____
_____

Name of prescribing physician(s)_____

Alcohol and Drugs

Have you or anyone close to you ever been concerned about your alcohol and/or drug usage? YES NO

If yes, please explain_____

_____

_____

Significant Events

Please check any significant events you have experienced:

____ Recent serious illness or injury to a family member or friend
____ Recent death in the family
____ Divorce or separation
____ Change in family structure (someone moved in/out of home, blending of families)
____ Victim of physical abuse
____ Victim of sexual abuse
____ Victim of rape/sexual assault
____ Domestic violence

____ Other significant trauma (please specify)_____

Family Health History

Have any family members (siblings, parents, aunts, uncles, cousins or grandparents) been diagnosed or treated for a mental health or substance abuse problem?
YES NO DON'T KNOW

Please explain if yes to above question:
_____
_____
_____
_____

Present Concerns

Name and address of referring person
_____
_____
_____

What concerns are bringing you to treatment?
_____
_____
_____
_____
_____

What do you hope to accomplish in therapy?
_____
_____
_____
_____
_____

Are there any cultural, racial, sexual orientation and/or religious issues that need to be considered when planning your treatment?
_____
_____
_____
_____

Thank you for completing this questionnaire.