# ADULT BACKGROUND AND HISTORY QUESTIONNAIRE

Name_____ Today's Date_____

## Education

Highest grade/level completed:_____
If attended college, name of college and degree(s):_____
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:_____
_____
Previous positions:_____

## Relationship Status

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

## Living Situation

Who lives in your home?

Name Relationship Age Birthdate

_____
_____
_____
_____
_____
_____

## Medical History

Name and address of primary care physician: Physician phone:

_____ _____
_____
_____ Date of last exam:_____

Please specify any significant medical problems:

_____
_____
_____
_____

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 | ____ | ____ |
| Frequent Worrying | ____ | ____ |
| Anxiety/Panic | ____ | ____ |
| Obsessive Thoughts | ____ | ____ |
| Compulsive Behavior | ____ | ____ |
| Sad/Depressed mood | ____ | ____ |
| Low Energy | ____ | ____ |
| Low Self Esteem | ____ | ____ |
| Difficulty Sleeping | ____ | ____ |
| Low Appetite | ____ | ____ |
| Eating concerns – strict dieting | ____ | ____ |
| Eating concerns – overeating | ____ | ____ |
| Eating concerns – binging and purging | ____ | ____ |
| Eating concerns – excessive exercise | ____ | ____ |
| Learning problems | ____ | ____ |
| Difficulty getting along with others | ____ | ____ |
| Difficulty with anger control | ____ | ____ |
| Violence towards others | ____ | ____ |
| Social skills problems | ____ | ____ |
| Suicidal thoughts | ____ | ____ |
| Suicide attempts | ____ | ____ |
| Cutting or mutilating body | ____ | ____ |
| Excessive energy/mania | ____ | ____ |
| Hallucinations/Delusions | ____ | ____ |
| Significant memory problems | ____ | ____ |

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 | Date Started | Reason | Prescribing Physician |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Health Behaviors**

How much alcohol do you drink?_____
Do you use drugs? YES NO If so, how much?_____
Have you or anyone close to you ever been concerned about your alcohol or drug use? YES NO
If yes, please explain_____
_____
_____

Smoke? YES NO Daily amount:_____
Regular exercise? YES NO Type and Frequency:_____
How is your diet? Poor Fair Healthy Excellent Special Diet:_____
Caffeine? YES NO Daily amount:_____

**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
____ Job loss
____ 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:

_____
_____
_____

**Legal History**

Any history of legal problems (such as being arrested)? YES NO
Please describe:_____

**Present Concerns**

What concerns are bringing you to treatment?

_____
_____
_____
_____
_____

What do you hope to accomplish in therapy?

_____
_____
_____
_____

Please indicate goals for therapy. Place a 1, 2, and 3 next to your three most important goals.

| | |
|---|---|
| ____ Improving communication with family/ spouse/ children/other:_____ | ____ Decreasing uncomfortable thoughts |
| ____ Becoming more effective as a parent | ____ Improving time management |
| ____ Getting along better with my family/friends/coworkers | ____ Reducing procrastination |
| ____ Improving social skills | ____ Changing my sleep habits |
| ____ Decreasing symptoms of anxiety | ____ Making decisions more effectively |
| ____ Decreasing panic attacks | ____ Being more effective at school or work |
| ____ Worrying less | ____ Improving anger control |
| ____ Decreasing symptoms of depression | ____ Discussing thoughts of harming myself |
| ____ Reducing emotional sensitivity | ____ Discussing thoughts of harming others |
| ____ Expressing my feelings more | ____ Accepting my mistakes |
| ____ Improving attention/focus | ____ Increasing positive thinking |
| ____ Improving self-esteem | ____ Increasing self-awareness |
| ____ Decreasing need to be "perfect" | ____ Awareness of how I come across to others |
| ____ Adjusting to a recent change | ____ Managing my health or weight |
| ____ Adjusting to a past incident | ____ Breaking a habit |
| | ____ Controlling my alcohol/drug use |
| | ____ Improving sexual relationship |

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

_____