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BACKGROUND INFORMATION

If completing this form for another person, please answer as the person would answer.

Name: _____ Nickname: _____

What pharmacy do you use? _____

If you were referred to us, who referred you? _____

What is their phone number? _____

Who lives with you? _____

Status: Single___ Married___ Widowed___ Divorced___ Separated___ Other_____

If you were married previously, please give dates: _____

Please tell us briefly why you want treatment: _____

When did you start having problems? _____

What has helped make it better? _____

What has made it worse? _____

Is this the worst it has been? _____

Have you been in therapy before? Yes No

Whom did you see? _____

When did you see them? _____

Was it helpful? Yes No

Please explain: _____

Do you have any previous psychiatric hospitalizations? Yes No

If so, when and where? _____

Have you ever attempted suicide? Yes No

If so, when and how? _____

If you have a previous diagnosis, what is it? _____

What medicines have you tried in the past, if any? _____

Are you currently on any psychiatric medications? Yes No

If so, please list names and doses:

Medication:	Dosage:

How is your appetite? _____

Do you have an eating disorder or a history of an eating disorder (i.e. throwing up, purging, restricting)? Yes No

How do you sleep? _____

Do you snore or use a CPAP? Yes No

Do you have nightmares? Yes No

How many in the last 2 weeks? Several days___ Often___ Nearly every day___

Has anyone ever abused/neglected you in any way? Yes No

If yes, please explain: _____

Do you make and keep friends easily? Yes No

How is your energy level? High Low Normal

Do you have any problems paying attention or sitting still? Yes No

Do you have problems with staying organized? Yes No

How is your concentration (i.e. can you concentrate on reading, etc.)? _____

Are you currently having any problems at work or school? Yes No

If yes, please explain: _____

What was the last grade you completed in school? _____

How did school go for you? _____

Did you have any learning disabilities? _____

Did you have an IEP or a 504 plan? _____

Are you sad or moody? Yes No

Are you fearful or anxious? Yes No

Do you find yourself having to repeat the same actions (for example: checking, counting or washing)? Yes No

If yes, please explain: _____

Do you have any phobias? Yes No

If yes, what of? _____

Do you have panic attacks? Yes No

If yes, please explain: _____

Have you ever been depressed? Yes No

If yes, please explain: _____

Do you have any problems with your weight? Yes No

Do you cry frequently? Yes No

Have you ever stayed awake for 2 or more days? Yes No

Have you ever been manic? Yes No
 Do you have times of intense or excessive spending? Yes No

Do you have tantrums, or are you angry or aggressive? Yes No
 Have you ever had violent behavior? Yes No

Have you ever had a substance abuse problem? Yes No
 Which substances? _____

Have you undergone treatment for substance abuse? Yes No
 Do you use marijuana (even medicinally)? Yes No
 Are you concerned about the amount of alcohol you drink? Yes No
 Have you had a DUI? Yes No
 Have you had a blackout? Yes No
 Do you have any legal charges related to substance abuse? Yes No
 Do you smoke cigarettes? Yes No

Are you presently having any legal issues (for example: suspension, expulsion, arrest, probation, bankruptcy, custody battle)? Yes No

If yes, which issues? _____

Are you involved in any litigation? Yes No

If yes, please explain: _____

Have you ever had a perceptual disturbance (i.e. seeing or hearing something when nothing was there)? Yes No

Please explain: _____

Have you purposely cut or hurt yourself in the past? Yes No

If so, how and when? _____

If female, is there any chance you could be pregnant? Yes No

Do you have problems in any of these areas? If so, please circle:

Constitutional	Sweats, weight changes, appetite, often get sick, always cold or hot
Respiratory	Wheezing, breathing, shortness of breath
Cardiac	Dizziness, fatigue, chest pain, limitations on exertion, heart palpitations, difficulty breathing while laying flat
GI	Trouble eating or drinking or swallowing, vomiting, constipation, diarrhea, abdominal pain, blood in stool, heartburn
GU	Soiling during day or night, excessive urination, strong odor to urine
Musculoskeletal	Muscle pain, weakness, rigidity, ticks, tremors, excessive clumsiness
Skin	Rashes, sores, itchy or sensitive skin
ENT	Trouble hearing, ear tubes, abnormal hearing exams, teeth/gum problems
Taste	Trouble with taste, trouble swallowing foods
Vision	Contacts or glasses, problems with seeing clearly, glaucoma
Speech	Stuttering, unclear speech, gone to speech therapy
Neurological	Weakness, staring spells, had a neurological evaluation

Gynecological	Breast cancer, ovarian cancer, STD, history of kidney or bladder stone
Endocrine	Problems with pancreas, or with pituitary thyroid or adrenal glands
Immune	Problems with easy bruising

Are you taking any other medications not already listed? If so, please list names and doses:

Medication:	Dosage:

Do you have any allergies to medication? Yes No

If yes, please list: _____

Any side effects to medications you have taken or are taking? Yes No

If yes, please list: _____

Do you currently have any active medical problems? Yes No

If yes, what are they? _____

Have you had any cardiac problems? Yes No

Do you have chronic pain? Yes No

Have you had a head injury or concussion? Yes No

If so, when? _____

Have you seen any other medical specialist within the last 5 years? Yes No

If so, for what purpose did you see them? _____

Please list any previous surgeries and year received: _____

Have you ever been hospitalized overnight for a reason other than the ones given above? Yes No

If so, for what cause? _____

Were you adopted? Yes No

Do you have any relatives who have suffered with an emotional disorder or mental illness? Yes No

If yes, please explain: _____

Do you have any relatives who have committed suicide? Yes No

If yes, who and when? _____

Do you have any relatives who have been hospitalized psychiatrically? Yes No

Have any of these relatives received treatment? Yes No

If so, was it helpful? Yes No Please explain: _____

Do you have any relatives with sudden death from cardiac arrhythmia? Yes No

Do you have friends that use drugs or are a bad influence? Yes No

What are your friends like? _____

Are you experiencing any relationship problems? Yes No

Occupation: _____ Employer: _____

How long at this occupation? _____ How long at present job? _____

How is work going for you? _____

Military service? Yes No

Are you experiencing any financial problems? Yes No

What things do you find stressful? _____

Who are the people who help you? _____

What are your talents? _____

What are your strengths? _____

What are your goals for treatment? _____

Will you make yourself available for appointments between 9 am and 3 pm? Yes No

Are firearms in your home? Yes No

Please Rank how often you have been bothered by any of the following problems in **the last 2 weeks**.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

The following questions are for children and adolescents only:

How much did your child weigh at birth (approximately)? _____

Were there any complications with birth (i.e. forceps, breech, labor induced, NICU stay, C-section)? _____

Did your child crawl and walk on time? _____

When did your child start talking? _____

At what age was your child toilet trained? _____

How does your child play with other children? _____

Did or does your child have any sensitivities to fabrics, noise, foods? _____

Did or does your child have any habits, mannerisms, or ticks – i.e. moving hands a certain way, flapping hands, walking on toes, etc? _____

Did or does your child have any unusual interests? _____

Does your child have any unusual storage habits (i.e. hiding or hoarding food, etc.)? _____

How is your child's behavior/temperament (ex: energetic, easy to soothe, etc)? _____

Do you consider your child soft hearted or hard hearted? _____

Why? _____

By my signature below, I attest that the above answers are true and correct to the best of my knowledge:

Signed:

Name Printed:

Date: _____