Background Information

Person completing this form: ☐ Self ☐ Other ________________________________
Name: ____ Sex: □ Male / □ Female

How many people live in your home? ______ Please list people below:

Name	Relationship to you	Age

School: _______________________________ Grade:__________ Phone: _______________________
Highest level of education completed: ____________________

List major symptoms you are having problems with:

Are your parents:

☐ Married

☐ Divorced you were how old? ______

☐ Separated you were how old? ______

☐ Widowed you were how old? ______

☐ Deceased Mother you were how old? _____

☐ Deceased Father you were how old? _____

Where were you raised (city, state)? _____________________ By whom? ________________________
How many children were in your family of origin? _______ What number are you? _____

How would you describe your relationship with your parents? ___________________________________
How would you describe your relationship with your siblings? ___________________________________
Please check any areas that were part of your childhood:

□ Difficult birth
□ Family member with a chronic illness
□ Death in the family
□ Economic difficulties
□ Alcohol/drug problems
□ Moved frequently
□ Family violence
□ Emotional abuse
□ Sexual abuse
____Mental
____Physical
____Sexual
____Spiritual
□ Other ____

Family history: Please indicate the psychiatric problems that may exist among relatives that are biologically related to you(Aunts, uncles, grandparents)

Disorder	Mother	Father	Siblings	Other Biological relative (please specify)
Depression				
Bipolar Disorder				
Suicide				
Suicide attempt(s)				
Anxiety Disorder				
Attention deficit				
Schizophrenia				
Tourette's Syndrome				
Alcohol Abuse				
Substance Abuse				
Inpatient psychiatric treatment				
Other Disorder				

Medical information: Are you in ☐ Good Health ☐ Fair Health ☐ Poor Health
Date of last physical examination? ___________________________________

Are you currently being treated by a doctor or taking medications prescribed by a doctor? ☐ Yes ☐ No

If yes, state the problems or condition(s) you are being treated for: ________________________
____

Physician's name: _______________________________ Phone: ___________________________

Please check any of the following conditions/problems you have experienced in the **last 12 months**

☐ Dizziness/fainting
☐ Breathing difficulty
☐ Pain/stress
☐ Blackout/seizures
☐ Nausea/vomiting
☐ Frequent headaches
☐ Fatigue
☐ Recent weight change
☐ Loss of appetite
☐ Difficulty concentrating
☐ Crying more easily
☐ Indigestion/ reflux
☐ Heart attack
☐ High blood pressure
☐ Stroke
☐ Shaking of hands, arms or legs
☐ Frequency or difficulty in urination
☐ Night chills
☐ Night sweats
☐ Lack of sleep, or trouble falling asleep
☐ Sleep disorder
☐ Trauma to the head
☐ Psychiatric hospitalizations
☐ Mitral valve
☐ Rheumatic heart
☐ Migraines
☐ Thyroid problems
☐ Tuberculosis
☐ Hay fever
☐ Arthritis
☐ Stomach ulcer
☐ Colitis
☐ Leukemia
☐ Bleeding tendency
☐ Kidney Disease
☐ Diabetes

What medications are you currently taking? (Please list)

Medication	Dosage	Prescribed by	Length of time taken

Please list disorders you have been treated for in the past:

Substance use: Please check and describe which of the following substance you are using or have used in the past

Substance use	Amount	Frequency	Age of first use	Date of last use
☐ Alcohol (Beer, wine, liquor, etc.)				
☐ Cannabis (marijuana, hash, etc.)				
☐Hallucinogens(LSD, PCP, Acid, etc.)				
☐ Inhalants (gas, glue, etc.)				
☐ Pain killers (Percocet, oxycodone, etc.)				
☐ Sedatives (Sleeping pills, nerve pills, etc.)				
☐ Stimulants (Crack, cocaine, etc.)				
☐ Tobacco products				
☐ Other				

Check all major areas affected by alcohol/drugs and describe below:
___Legal ___Physical ___Family ___Marital ___Social ___Financial ___Work ___School

Have you ever felt you should cut down on your use of alcohol/drugs? ☐ Yes ☐ No

Have you recently been abusing or withdrawing from the use of alcohol, medication or illegal drugs? ☐ Yes ☐ No

Have you recently been taken off or stopped taking hypertension pills or birth control pills? ☐ Yes ☐ No

Past hospitalizations: ☐ Yes ☐ No (If yes, please list below)

Date	Reason	Hospital/facility

Have you had previous counseling, received EAP services, or been treated for chemical dependency? ☐ Yes ☐ No (If yes, please list below)

Facility / Counselor	Date(s)	Reason	Helpful?