BACKGROUND QUESTIONNAIRE

Please take a moment to read and fill out the following questions. The information that you provide is an important step in the psychological evaluation process and allows me to better serve you.

FAMILY DATA

Name: _____ Today's date: _____
Birthdate: _____ Age: _____ Sex (circle one) Male Female
County of residence: _____
Person filling out this form (circle one): Self Child Mother Father Stepmother Stepfather Grandparent
Other (please explain): _____

Marital Status: ____ Married ____ Divorced ____ Remarried ____ Never married
Spouse/Partner (Name) _____

List all people currently living in household:

Name	Relationship to you	Age

If any children are living outside the home, list their names and ages: _____

Main concern (what brought you here)_____

PSYCHIATRIC FAMILY GENETIC HISTORY QUESTIONNAIRE

BACKGROUND: As a group, psychiatric disorders have a relatively high heritability. This means that genetics is a major factor in the development of these problems and illnesses. A careful assessment of the family history of these problems is quite helpful in diagnosis and treatment planning. With the human genome project now completed and ever more information available about genetics, this family history information is becoming increasingly important. A family history of problems suggests the presence of genetic risk. Remember, genetic risk increases the probability of developing a similar or related problem, but genes are not destiny. Many other factors (including we hope, early recognition and treatment) play an important role in whether a problem will develop and at what level of severity.

GENERAL DIRECTIONS: This is a lengthy and somewhat complicated questionnaire, but please hang in there and take it step by step since it is quite important. For a genetic history we are considering your "blood relatives." You can greatly increase how accurate and complete this information is by making sure to follow these proven principles:

a) get information from more than one family member on your mother's and father's sides
b) first identify all close relatives by name and age
c) take time to carefully consider each and every close relative for each kind of problem, and
d) include whatever information you have

An adult patient will typically complete this history themselves, consulting members from both sides of their family. Read all the directions for Step A, and then complete it. Next, read all the items for Step B and complete it. Take a quick look now at the accompanying "Recording Form" you will use to record the information.

STEP A: Listing ALL the close relatives (simpler than it looks).

1. Write in who completed the **mother's side** history (e.g., Mom-Julie), and circle yes or no regarding whether other family members were consulted (hopefully yes!).
2. Write your mother's first name and age. For age, if the person is 20 or older, simply write the decade of life (e.g., 40s), if younger than 20, then write your best estimate of the age.
3. Then write the first names of your grandmother and grandfather and their ages.
4. If someone is deceased, write the age at which they had died (e.g., 50s), and draw a light diagonal line through the age.
5. Next write down **all** maternal (mother's blood relatives) aunts and uncles first names (do not include half aunts/uncles).
6. Write down **all** brothers and sisters (listed as "siblings"). Include half-siblings, and put ½ after the word "sibling". For siblings, indicate if they are male (m) or female (f) after their age (e.g., 14f). If you have children, these can be listed in the "Other" section or on the back.
7. Now repeat all the above steps for your **father's side**.

Step B: Listing the family history.

1. Carefully read through the list of problems on the next page.
2. Have a conversation with one or two members on the mother's side of the family to gather information.
3. Start at the top with the mother's side (the patient's mother) and systematically go through each person. Think about all you know about this person, and then deliberately go through each item on the problem list to consider whether each of the problems is present in that person's history.

4. Each time the problem is present, indicate that by writing the "code" (the bold face letters) on the line following the person's age. Write as many problems as are present (e.g., hosp. suid. diag. med. drug).
5. On the full line below the family member's name, write additional details or information (e.g., hosp. in 20s, bipolar, suicide attempt, lithium, marijuana). Use the back of the paper to add more details if available.
6. Now repeat these steps with the father's side.
7. Celebrate, you've finished! Keep a copy for yourself.

Problem List

(Please remember to consider each of these questions for each of the close relatives)

1. Has this relative ever been **hospi**talized for psychiatric or substance abuse problems?
2. Has this relative ever made **suici**dal statements or had suicidal behavior?
3. Has this relative ever had clearly bizarre/**psych**otic behavior or thinking, hallucinations, or very strange untrue beliefs (delusions)?
4. Has this relative ever been treated with **medi**cations for a psychiatric or emotional/behavioral problem (e.g., medicine for depression, anxiety, or hallucinations)? If known, write the name of the medicine.
5. Has this relative ever had a **diag**nosis for a psychiatric or emotional/behavioral problem? This would include problems such as depression, mania, bipolar disorder, anxiety, ADHD/hyperactivity, schizophrenia, tic disorders, panic disorder, enuresis, etc.
6. Has this relative ever had persistent moodiness or rapid emotional or mood **swings** that caused very serious problems?
7. Has this relative ever had **crimi**nal behavior involving the police or courts (include if this was in the juvenile justice system)?
8. Has this relative ever had an **alco**hol abuse problem?
9. Has this relative ever had a **drug** abuse problem?
10. Has this relative ever had problems with recurrent **aggr**ession, violence, or serious explosive anger?
11. Has this relative ever had problems with **learn**ing or a learning disorder (e.g., reading disorder or dyslexia)?
12. Has this relative ever had problems with a **dev**elopmental disorder (e.g., mental retardation or autism-like problems)?
13. Has this relative ever had problems with a known **gene**tic disorder that runs in the family?

Family Genetic History Recording Form

Patient's First and Last Name, Age, and Gender: _____

MOTHER'S Side: Completed by: _____ Consulted others: Yes or No

Relationship to Patient	First Name	Age	History
Mother			
Grandmother			
Grandfather			
Aunt/Uncle			
Aunt/Uncle			
Aunt/Uncle			
Oldest Child/Sibling			
Next Child/Sibling			
Next Child/Sibling			
Other: _____			

FATHER'S Side: Completed by _____ Consulted Others: Yes or No

Relationship to Patient	First Name	Age	History
Father			
Grandmother			
Grandfather			
Aunt/Uncle			
Aunt/Uncle			
Aunt/Uncle			
Oldest Child/Sibling			
Next Child/Sibling			
Next Child/Sibling			
Other: _____			

SOCIAL, PEER, AND EDUCATIONAL HISTORY

(check those which are consistent with your history)

___ Had difficulty with reading
___ Had difficulty with arithmetic
___ Had difficulty with spelling
___ Had difficulty with writing

___ Had difficulty with other subjects (please list)
_____
_____
_____

___ Had an identified learning disability (if yes, please describe):
_____
_____

___ Was in a special education class (If yes, please describe):
_____
_____

___ Had difficulty socially (if yes, what grade and why):
_____
_____

___ Had difficulty with behavior (if yes, please describe):
_____
_____

___Educational attainment:
_____
_____

GENERAL MEDICAL HISTORY

How is your general health currently? Excellent ☐ Good ☐ Fair ☐ Poor ☐ Explain: _____
_____

Have there been concerns about growth or weight? No ☐ Yes ☐ Explain: _____
_____

Any problems with vision or hearing? No ☐ Yes ☐ Explain: _____
_____

Any serious chronic illnesses now or in the past? No ☐ Yes ☐ Explain:_____
_____

Please list any overnight hospitalizations (with reasons and age)? _____
_____

Any surgeries (for what and at what age); any continuing related problems? No ☐ Yes ☐ Explain: ___
_____
_____

Serious injuries? No ☐ Yes ☐ Explain: _____
_____

Allergies to medicine or serious allergies? No ☐ Yes ☐ Explain: _____
_____

When was your last complete physician examination: Month/year: _____ Were there any problems identified? No ☐ Yes ☐ Explain: _____

_____

Any special dietary requirements? No ☐ Yes ☐ Explain: _____

_____

Has you had any of the following (please give details):

head injuries: No ☐ Yes ☐ Explain: _____

_____

episodes of loss of consciousness: No ☐ Yes ☐ Explain: _____

_____

current problems with sleep: No ☐ Yes ☐ Explain: _____

_____

seizures: No ☐ Yes ☐ Explain: _____

_____

recurrent headaches: No ☐ Yes ☐ Explain: _____

_____

abnormal movements, tics, or tremors: No ☐ Yes ☐ Explain: _____

_____

change in sensation: No ☐ Yes ☐ Explain: _____

_____

change in movement, coordination, or walking: No ☐ Yes ☐ Explain: _____

_____

change in speech: No ☐ Yes ☐ Explain: _____

_____

recurrent ear infections: No ☐ Yes ☐ Explain: _____

_____

changes in weight or concern about eating problems or disorders (e.g., anorexia) : No ☐ Yes ☐
Explain: _____

_____

persistent fatigue or fevers: No ☐ Yes ☐ Explain: _____

_____

skin changes: No ☐ Yes ☐ Explain: _____

_____

breathing or lung problems: No ☐ Yes ☐ Explain: _____

_____

heart or blood pressure problems: No ☐ Yes ☐ Explain: _____

_____

fainting or irregular heart beat: No ☐ Yes ☐ Explain: _____

_____

urination problems or wetting: No ☐ Yes ☐ Explain: _____

_____

bowel problems or soiling: No ☐ Yes ☐ Explain: _____

_____

liver injury, infection, or other problems: No ☐ Yes ☐ Explain: _____

_____

recurrent nausea, vomiting, or diarrhea: No ☐ Yes ☐ Explain: _____

_____

delays or advances in onset of puberty: No ☐ Yes ☐ Explain: _____

_____

menstrual problems or sexually transmitted infections: No ☐ Yes ☐ Explain: _____

kidney injury, infections, or other problems: No ☐ Yes ☐ Explain: _____

problems with bones, muscles, or joints, including recurrent pain: No ☐ Yes ☐ Explain: _____

other: No ☐ Yes ☐ Explain: _____

Are you taking herbals, dietary supplements, and/or vitamins No ☐ Yes ☐
Please list the supplements and amount taken: _____

Are you taking any regular medications (include nonprescription)? No ☐ Yes ☐

Please list the medication and current dose: _____