



CLINICAL PSYCHOLOGISTS, P.C.

Background Questionnaire

This questionnaire is to help us get an understanding of your experiences and situations, so that we help you receive the best possible treatment. Feel free to leave any questions blank which do not apply or which you prefer not to answer in this format. We will follow-up with you on many of these items.

Your Name: _____ Today's Date: _____

Please summarize your reason for seeking services at this time.

When did you first begin to experience or notice the above concerns you're seeking help for?

On a scale of 1-10, where 1 is the least amount of concern/distress you have ever experienced, and 10 is the absolute highest amount of concern/distress you have ever experienced, what number would you assign for your level of distress in the last week? _____

EDUCATIONAL/MILITARY BACKGROUND:

What is the highest school degree you have earned? _____ Are you in school now? _____

During school, did you receive any: _____ Special education? _____ Evaluation for a learning disability?
_____ Tutoring? _____ Alternative schooling? _____ Disciplinary actions?

Have you ever served in the military? _____ Yes _____ No

If yes, please answer the following: Date of service: _____
Type of discharge: _____
Combat experience? _____
Highest Rank: _____

WORK/VOCATIONAL HISTORY

What is your current occupation? _____

Current Employer: _____

How long have you been employed in your present position? _____

Are you satisfied with your current job? _____ Yes _____ No

Since becoming an adult, how many different jobs have you held? _____

Have you had any periods of unemployment, which lasted four months or longer? __ Yes __ No

If yes, please describe circumstances briefly: _____

Have you made any career changes? _____ Yes _____ No

If yes, what was/were your previous occupation(s)? _____

Any major changes in your current work situation during the past year? _____ Yes _____ No

If yes, please describe: _____

MEDICAL HISTORY

Please list any medical conditions you have, the type of treatment you are receiving for each, and your treating physicians.

Please list all medications you are currently taking, including dosages if you know them:

Medication	Dosage	Prescribed By
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____

Date: _____

Please list all "over the counter" medications, sleep aids, vitamins, minerals, herbs and/or dietary supplements you are currently using:

Agent	Dosage	Condition/Problem
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had major surgery? _____ Yes _____ No

Describe: _____

Have you ever had a head injury which resulted in loss of consciousness or which may have been associated with a concussion or with problems in thinking, emotion or behavior? Yes No

Have you ever had an extremely high fever (greater than 103 degrees F.)? Yes No

Have you ever fainted or had a seizure? Yes No

Do you have any medication allergies or sensitivities? Yes No
If yes, please specify: _____

Do you have any food or seasonal allergies or sensitivities? Yes No
If yes, please specify: _____

Do you regularly engage in physical exercise? Yes No
If yes, please describe: _____

Please list any other medical conditions or concerns:

Date of last medical examination: _____

Name of Physician: _____ Contact #: _____

Would you like me to contact your doctor to coordinate your treatment with him/her: Yes No

PRIOR EXPERIENCE WITH PSYCHOLOGICAL TREATMENT

Have you been in counseling or psychotherapy previously? Yes No
If yes, please indicate when, and by whom: _____

Was your prior counseling/psychotherapy helpful? Yes No

PREVIOUS PSYCHOLOGICAL/PSYCHIATRIC TREATMENT, CONT.

Have you ever taken medications for psychological/psychiatric reasons? Yes No
If yes, please indicate when, and for what conditions/problems: _____

Have you ever been hospitalized for psychological/psychiatric reasons? Yes No

Has anyone in your family (parents, grandparents, siblings, children, other relatives) been diagnosed and/or treated for psychological/psychiatric condition(s)? Yes No
If yes, please describe _____

CURRENT AND PAST USE OF ALCOHOL AND OTHER SUBSTANCES

If you currently drink alcohol, please describe the type of alcoholic beverages, the amounts, and the frequency: _____

If you currently drink alcohol, how many days in the past year have you had 4, 5 or more drinks in one day? _____

If you have used, or currently use, any recreational drugs, please describe which ones and your pattern(s) of use: _____

Have you ever tried to cut down on your use of alcohol or drugs? ___ Yes ___ No

Has anyone gotten angry at you because of your alcohol or drug use? ___ Yes ___ No

Have you ever felt guilty or worried about your use of alcohol or drugs? ___ Yes ___ No

Have you ever felt the need for an "eye-opener" in the morning? ___ Yes ___ No

Have you ever received outpatient alcohol and/or drug treatment or detoxification services? ___ Yes ___ No

Have you ever received inpatient alcohol and/or drug treatment or detoxification services? ___ Yes ___ No

Has anyone in your family had a problem with alcohol or drugs? ___ Yes ___ No

Please describe your past and current use of cigarettes and/or caffeine: _____

LEGAL ACTIONS/PROCEEDINGS

Please check all legal actions or proceedings you have been a part of:

- | | | |
|-------------------------------------|-------------------------------|-------------------------|
| ___ Arrests/Assault | ___ Arrests/Other* | ___ DUI (how many? ___) |
| ___ Restraining/protective order(s) | ___ Child Protective Services | ___ Divorce/custody |
| ___ Disability claim(s) | ___ Other (describe) _____ | |

PERSONAL INFORMATION

Place of Birth: _____ Where were you raised? _____

Have you experienced a loss (death, divorce, or significant situational loss) in the past 24 months? ___ Yes ___ No

Did you experience any losses as above during childhood or adolescence? ___ Yes ___ No
If yes, please indicate whom, and your age at the time of loss: _____

Have you relocated or changed jobs within the past 24 months? Yes No

How many siblings do you have, and what is your birth order among them? _____

Were you adopted or separated from your birth parents during childhood? Yes No

Were/are your parents divorced? Yes No

If yes, please indicate your age at the time of their separation: _____

Please indicate your parents' current ages, or their ages at the time of their deaths: _____

Mother's occupation(s)/highest level of education: _____

Father's occupation(s)/highest level of education: _____

Has religion or spirituality played an important role in your life? Yes No

Has race, ethnicity or culture played an important role in your life? Yes No

Do you own or have access to firearms? Yes No

Have you experienced physical, emotional or sexual trauma or abuse? Yes No

If yes, is this something we can talk about more in person? Yes No

Please check relationship status: Married? Separated?

Divorced? Widowed?

Committed Relationship?

Name of significant other: _____ Number of years together? _____

Please describe the quality of your relationship: Excellent Good

Needs Improvement Poor

Possibly ending relationship

Name: _____ Date: _____

Do you have children/stepchildren? Yes No

Names & Ages _____

What are some of the best (most positive) life experiences you have had?

What do you consider to be your strengths or talents?

What are some of the things for which you feel a sense of personal accomplishment/satisfaction?

How have you gotten through times of hardship or stress in the past?

What's going right in your life right now?

Who, if anyone, can you count on now when you need them? _____

Who, if anyone, really "gets" you and understands how you think or feel or do things? _____

What is it like when you are in a satisfying relationship (with peers, colleagues, friends, family members or loved ones)? _____

Please use the space below to provide any additional information that you think would be important for me to know, including your goals for our work together.

Thank you for taking the time to complete this questionnaire.

Signature

Reviewed by: _____
Clinical Psychologists, P.C.