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Adult Background Questionnaire

This questionnaire is intended to help me gain an understanding of your life experiences and current difficulties so that I can better help you receive the best possible services. Feel free to leave blank any questions which do not apply or which you prefer not to answer in this format. I will ask you follow-up questions on many of these items.

Your Name: _____Today's Date: _____

Birth date: _____/_____/_____ Age: _____

Address: _____

City, State: _____ Zip: _____

Home Phone: (_____) May I leave a message? □ Yes □ No

Cell Phone: (_____) May I leave a message? □ Yes □ No

E-mail: _____May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Please write a brief description of the reasons you are seeking services at this time. What are your goals for our work together?

_____

_____

_____

_____

When did you first begin to experience or notice the above difficulties for which you are seeking help?

_____

_____

_____

_____

Personal information

Place of birth: _____ Where were you raised? _____

Race: _____Ethnicity: _____

What is your sexual orientation? _____Gender: _____

What is your current religious or spiritual identification? _____

How would you identify your current socioeconomic status? _____

What do you consider to be your strengths or talents?

_____

_____

_____

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

_____

_____

_____

What is going on in your life now that contributed to you seeking an evaluation?

_____

_____

_____

Have you experienced a lost (death, divorce, or significant situational or relational loss) over the past year? □ Yes □ No

Did you experience any losses as above during childhood or adolescence? □ Yes □ No

If yes, please indicate who and your age at time of loss:

_____

_____

_____

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

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

Current and past use of alcohol and other substances: If you are currently drinking or using recreational drugs please describe your pattern of use, such as the type of substance you are using, the amounts, and the frequency:

_____

_____

_____

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

Has anyone gotten angry with 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 received outpatient alcohol and/or drug treatment? □ Yes □ No

Have you ever received inpatient alcohol and/or drug treatment? □ Yes □ No

Please describe your past and current use of nicotine products and/or caffeine:

_____

_____

_____

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

_____

_____

_____

Developmental History

This section is important to our work and many people struggle with recalling the following information. If you have difficulty answering the questions, please ask a parent or indicate that you do not know the answer.

Did you have difficulty meeting any gross motor milestones, such as delay in walking, learning to ride a bike, etc? □ Yes □ No If yes please describe:

_____

_____

_____

Did you have any difficulty with activities that require the use of fine motor skills, such as holding a pencil, writing, using scissors, etc? □ Yes □ No If yes please describe:

_____

_____

_____

Language/Communication

At what age did you first speak? _____

What were your first words? _____

At what age did you first use phrased speech, e.g. a sequence of two words or more? _____

Did you have any delays in spoken language? □ Yes □ No If yes, please describe:

_____

_____

_____

Did you display any advancement in language development, for example using above average sentences or vocabulary for your age?

_____

_____

_____

Social Development

As an infant did you engage in common baby games such as “peek-a-boo”? □ Yes □ No

As a toddler did you respond to your name? □ Yes □ No

As a child did you play with other children? □ Yes □ No

Did you have any intense areas of interest or focus as a child? □ Yes □ No

Please describe your social experiences as a child/adolescent:

_____

_____

_____

Did you have difficulty developing and/or maintaining friendships? □ Yes □ No If yes, describe

_____

_____

_____

Do you have any developmental or acquired disabilities? □ Yes □ No If yes, describe

_____

_____

_____

Did you receive any Occupational Therapy (OT)? □ Yes □ No If yes, describe:

_____

_____

_____

Did you receive any Speech and Language services? □ Yes □ No If yes, describe:

_____

_____

_____

Biological Family

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

1. Name: _____Age: _____ 4. Name: _____Age: _____

2. Name: _____Age: _____ 5. Name: _____Age: _____

3. Name: _____Age: _____ 6. Name: _____Age: _____

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

Were/are your parents divorced? □ Yes □ No If yes, what was your age at the time? _____

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 anyone in your family (parents, grandparents, siblings, children, or other relatives) been diagnosed and/or treated for psychological/psychiatric condition(s)? □ Yes □ No

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

Medical History

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

_____

_____

_____

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

Medication	Dosage Prescribed	Reason Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Have you ever fainted or had a seizure? □ Yes □ No

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

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

Do you have any medication, food or seasonal allergies or sensitivities? □ Yes □ No

Do you have any sensory over or under-responsivity, e.g., sensitivity to sounds or certain forms of lightening, clothing? □ Yes □ No If yes, please describe:

_____

_____

_____

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

_____

_____

_____

Please list any other medical conditions or concerns:

_____

_____

_____

Do you have a primary care physician? □ Yes □ No

If so, who: _____ Date of last medical examination: _____

Prior experience with psychological/psychiatric treatment

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

_____

_____

_____

Have you had a previous diagnostic or psychological evaluation completed? □ Yes □ No
If yes, please indicate when and by whom:

_____

_____

_____

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

_____

_____

_____

Have you ever been hospitalized for psychological/psychiatric reasons? □ Yes □ No
If yes, please describe:

_____

_____

_____

Educational Background

Please outline your educational history and the schools you attended.

Elementary School: _____

Middle School: _____

High School: _____

College/Vocational School: _____

What is the highest school degree you have earned? _____
Did you receive special education services? □ Yes □ No If yes describe services:

_____

_____

_____

Have you ever undergone an evaluation for a learning disability? □ Yes □ No If yes describe:

_____

_____

_____

Did you have an Individualized Education Plan? □ Yes □ No If yes describe:

_____

_____

_____

Employment History

Are you currently employed: □ Yes □ No If yes, what is your current occupation?

_____

_____

Who is your employer: _____Are you satisfied with your current job? □ Yes □ No

How long have you been employed at your current position? _____

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

Please briefly describe your employment history since you turned 18 years old (including place of employment, position and duration of job).

_____

_____

_____

_____

_____

Have you had any periods of unemployment, which lasted four months or longer? □ Yes □ No
If yes, please briefly describe circumstances:

_____

_____

_____

Have you made any career changes? □ Yes □ No

Have you had any major changes in your work situation during the past year? □ Yes □ No

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

☐ Arrests/assault ☐ Arrests/other ☐ Divorce/custody ☐ Restraining/protective order(s)

☐ Child Protective Services ☐ Disability claim(s) ☐ DUI (How many? _____)

Have you ever been charge/convicted of a crime? □ Yes □ No If yes please describe:

_____

_____

_____

Please use the space below to provide any additional information that you think would be important for me to be aware of.

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. I appreciate your time. By signing this you certify that all of this information is true and accurate to the best of my knowledge.

Your signature: _____ Date: _____

Print Name: _____

Name: _____