ADULT BACKGROUND QUESTIONNAIRE

FAMILY DATA

Name: _____ Today's date: _____

Address: _____ Apt. #: _____

_____ Zip Code: _____

School/Employment: _____ Birthday: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Education/Occupation: _____

Mother's Name: _____ Occupation/Education: _____

Father's Name: _____ Occupation/Education: _____

Marital Status of Parents: _____ Your marital status: _____

If parents are separated or divorced, how old were you when the separation occurred? _____

List all people living in your household:

NAME	RELATIONSHIP

List all of your brothers and sisters:

NAME	AGE	EDUCATION	OCCUPATION

Primary language spoken in the home:

_____

Other languages spoken in the home:

_____

PRESENTING PROBLEM

Briefly describe your current difficulties: _____

_____

_____

_____

_____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____

What seems to help the problem? _____

_____

What seems to make the problem worse? _____

_____

Have you received evaluation or treatment for the current problem or similar problems? Yes _____ No _____

If yes, when and with whom? _____

Are you on any medication at this time? Yes _____ No _____

If yes, what kind and on what schedule: _____

_____

(PLEASE REMEMBER TO BRING MEDICATIONS WITH YOU IF YOU WILL NEED THEM DURING THE EVALUATION.)

EDUCATIONAL HISTORY

List schools attended:

NAME	LOCATION	GRADE

Place a check next to any educational problems you exhibited:

_____ Difficulty with reading

_____ Difficulty with arithmetic

_____ Difficulty with spelling

_____ Difficulty with writing

_____ Difficulty with other subjects (please specify) _____

Did you enjoy school? Yes _____ No _____

Were you in a special education class? Yes _____ No _____

If yes, what type of class? _____

Were you held back a grade? Yes _____ No _____

If yes, which grade and why? _____

Did you ever receive special tutoring or therapy in school? Yes _____ No _____

If yes, please describe: _____

_____

MEDICAL HISTORY

Place a check next to any illness or condition that you have had. When you check an item, also note the approximate date (or age) of the illness.

ILLNESS OR CONDITION	DATE(S) OR AGE(S)	ILLNESS OR CONDITION	DATE(S) OR AGE(S)
_____ MEASLES	_____	_____ DIZZINESS	_____
_____ GERMAN MEASLES	_____	_____ FREQUENT OR SEVERE HEADACHES	_____
_____ MUMPS	_____		
_____ CHICKEN POX	_____	_____ BACK PAIN	_____
_____ MENINGITIS	_____	_____ MEMORY PROBLEMS	_____
_____ ENCEPHALITIS	_____	_____ EXTREME TIREDNESS, WEAKNESS OR FATIGUE	_____
_____ FEVER OF UNKNOWN ORIGIN	_____	_____ RHEUMATIC FEVER	_____
_____ CONVULSIONS	_____	_____ EPILEPSY	_____
_____ ALLERGIES	_____	_____ TUBERCULOSIS	_____
(ALLERGIES TO WHAT?)	_____	_____ BONE OR JOINT DISEASE	_____
_____ INJURIES TO HEAD	_____	_____ ANEMIA	_____
_____ LOSS OF CONSCIOUSNESS	_____	_____ JAUNDICE/HEPATITIS	_____
		_____ DIABETES	_____
_____ BROKEN BONES	_____	_____ CANCER	_____
(WHICH BONES?)	_____	(WHAT TYPE?)	_____
_____ HOSPITALIZATIONS	_____	_____ HIGH BLOOD PRESSURE	_____
(FOR WHAT REASON?)	_____	_____ HEART DISEASE	_____
		_____ ASTHMA	_____

MEDICAL HISTORY (CONTINUED)

Place a check next to any illness or condition that you have had. When you check an item, also note the approximate date (or age) of the illness.

ILLNESS OR CONDITION	DATE(S) OR AGE(S)	ILLNESS OR CONDITION	DATE(S) OR AGE(S)
_____ SURGERIES	_____	_____ BLEEDING PROBLEMS	_____
(WHAT KIND?)	_____	_____ ECZEMA OR HIVES	_____
_____		_____ DEPRESSION	_____
_____ EAR PROBLEMS	_____	_____ SUICIDE ATTEMPTS	_____
_____ VISUAL PROBLEMS	_____	_____ DIFFICULTY CONCENTRATING	
_____ FAINTING SPELLS	_____	_____ STOMACH PROBLEMS	_____
_____ PARALYSIS	_____	_____ OBESITY	_____
_____ MIGRAINES	_____	_____ OTHER	_____
		(SPECIFY)	_____

DEVELOPMENTAL HISTORY

During pregnancy, did your mother take any medications? Yes _____ No _____

If yes, what kind? _____

Were there any complications related to your birth? (examples: long labor, forceps delivery, emergency Caesarian, etc.) _____

Were you premature? Yes _____ No _____ If so, by how much? _____

What was your approximate birth weight? _____

Were there any medical problems during your early infancy? _____

Were there any problems in your early development? (examples: walked late, delayed speech, failure to thrive, etc.) _____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check by any behavior or problem you currently exhibit or have had in the past:

	(Check)	Age(s) when first exhibited
Difficulty with speech	_____	_____
Difficulty with hearing	_____	_____
Difficulty with understanding language	_____	_____
Difficulty with language expression	_____	_____
Difficulty with vision	_____	_____

SOCIAL AND BEHAVIOR CHECKLIST (CONTINUED)

Place a check by any behavior or problem you currently exhibit or have had in the past:

	(Check)	Age(s) when first exhibited
Difficulty with coordination	_____	_____
Prefer to be alone	_____	_____
Do not get along well with family	_____	_____
Do not get along well with coworkers/peers	_____	_____
Aggressiveness	_____	_____
Shyness or timidity	_____	_____
Are more interested in things (objects) than in people	_____	_____
Engage in behavior that could be dangerous to self or others (describe:) _____	_____	_____
Special fears, habits, or mannerisms (describe:) _____	_____	_____
Excessive worrying (describe:) _____ _____	_____	_____
Nailbiting	_____	_____
Too fearful or anxious	_____	_____
Quick temper	_____	_____
Frequent nightmares	_____	_____
Difficulty sleeping (describe:) _____ _____	_____	_____
Difficulty concentrating	_____	_____
Difficulty completing tasks	_____	_____
Poorly organized	_____	_____
Poor eating habits	_____	_____
Stubbornness	_____	_____
Frequently sad or unhappy	_____	_____
Excessively active	_____	_____
Clumsiness	_____	_____
Blank spells (or “Black Outs”)	_____	_____
Impulsivity	_____	_____
Sudden changes in mood or feeling	_____	_____
Slowness to learn	_____	_____
Giving up easily	_____	_____
Other (describe:) _____	_____	_____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of your immediate family has had. When you check an item, please note the member's relationship to you:

CHECK	CONDITION	RELATIONSHIP TO YOU
_____	ALCOHOLISM	_____
_____	CANCER	_____
_____	DIABETES	_____
_____	HEART TROUBLE	_____
_____	LEARNING PROBLEMS	_____
_____	NERVOUS OR PSYCHOLOGICAL PROBLEMS	_____
_____	DEPRESSION	_____
_____	SUICIDE ATTEMPT	_____
_____	OTHER (DESCRIBE:)	_____

OTHER INFORMATION

What are your favorite activities? _____

_____

What activities would you like to engage in more often than you do at present? _____

_____

What activities do you like least? _____

_____

Have you ever been in trouble with the law? Yes _____ No _____

If yes, please describe briefly: _____

_____

Have you ever sought help from a mental health professional? Yes _____ No _____

If yes, please give details: _____

_____

Do you drink alcohol? Yes _____ No _____ If yes, how much? _____ How often? _____

What kind? _____

Do you smoke cigarettes? Yes _____ No _____ If yes, how much? _____

Do you use any recreational substances? Yes _____ No _____ If yes, how much? _____

How often? _____ What kind? _____

What are your strengths and assets? _____

_____

Is there any other information that you think may help me in working with you? _____

_____

_____

_____

Please attach copies of relevant medical, psychological, or educational reports. Thank you.