

BACKGROUND HISTORY QUESTIONNAIRE

Name: _____ Sex M _____ F _____

Address: _____

Telephone Number: _____

Date of Birth: _____ Age: _____

Referred By: _____

Referral Question or Presenting Problem: _____

Primary Physician: _____

Other Specialists (include name and specialty): _____

MEDICAL HISTORY:

Previous hospitalizations, surgeries or accidents (describe when occurred, age, length of stay): _____

Serious illnesses: _____

Medical problems currently affecting you: _____

Family history of serious illnesses: _____

Previous loss of consciousness related to head injury or concussion - If yes, describe circumstances, when occurred, medical treatment: _____

History of seizures: _____

Other neurological disorders (stroke, hemorrhage, etc.): _____

Family history of neurological illness – If yes, describe: _____

Current medications (name and dosage): _____

Vision difficulties: _____

Hearing difficulties: _____

Previous tests performed: (please include year performed and results)

EEG: _____

Head CT scan: _____

Brain MRI: _____

Psychological Testing: _____

Neuropsychological Testing: _____

Other medical findings or diagnoses: _____

PSYCHIATRIC HISTORY:

History of emotional disorder/psychiatric treatment (diagnosis if known, age diagnosed,
treating physician, medications prescribed): _____

When did you first seek psychiatric treatment? _____

For what problems did you seek treatment? _____

Was treatment helpful? _____

Current psychiatrist: (name, when treatment started, focus of treatment) _____

Current medications prescribed (name, dosage): _____

Medications taken in the past (name, dosage): _____

Current therapist: (name, when treatment started, focus of treatment) _____

Inpatient hospitalizations (hospital, age, nature and duration of treatment):

Previous suicide attempts (age, injuries): _____

Family history of psychiatric treatment or illness: _____

SUBSTANCE USE HISTORY:

Previous/current use of:

Nicotine (age began using, how long using, current usage): _____

Alcohol (age began using, how long using, current usage): _____

Ever experience blackouts or withdrawal symptoms? _____

Recreational drugs (specify drug, age began using, how long using, current usage):

Drug of choice, if any: _____

Formal treatment for drug or alcohol abuse (detoxification, rehabilitation, AA or NA).

If yes, describe: _____

PERSONAL HISTORY:

Place of Birth: _____ Where Raised: _____

Native Language: _____

Handedness: _____

Developmental milestones (e.g. walking, talking) attained early/late/within normal limits: _____

Education including high school (include name of institution, degree obtained, year of graduation): _____

School Problems (repeated grades, failed classes, special education, tutoring): If any, please describe: _____

Ever diagnosed with a learning disability or Attention Deficit/Hyperactivity Disorder?

If yes, when and by whom: _____

Behavioral Problems as a child (if yes, describe): _____

Current Occupation (include job title, company name): _____

How long at current job? _____

Last Job: _____

Previous Work History: _____

Current Marital Status: S _____ M _____ D _____ W _____

If married, separated, divorced or widowed, please note when: _____

List those individuals living with you (the patient) at the present time:

Name	Sex	Age	Relationship	Education	Occupation	Health
_____	___	___	_____	_____	_____	_____
_____	___	___	_____	_____	_____	_____
_____	___	___	_____	_____	_____	_____
_____	___	___	_____	_____	_____	_____
_____	___	___	_____	_____	_____	_____

How long at current residence? _____

List immediate family members not living with you (children, siblings, parents, etc.):

Name	Sex	Age	Relationship	Education	Occupation	Health
_____	___	___	_____	_____	_____	_____
_____	___	___	_____	_____	_____	_____
_____	___	___	_____	_____	_____	_____
_____	___	___	_____	_____	_____	_____
_____	___	___	_____	_____	_____	_____

CURRENT COMPLAINTS

Physical symptoms & changes:

Weakness:	Y / N	Hearing defects:	Y / N
Numbness:	Y / N	Problems with taste:	Y / N
Muscle tics/twitches:	Y / N	Problems with smell:	Y / N
Clumsiness:	Y / N	Bladder/bowel control:	Y / N
Headache:	Y / N	Change in appetite/weight:	Y / N
Pain:	Y / N	Change in sleep pattern:	Y / N
Dizziness:	Y / N	Seizures:	Y / N
Nausea:	Y / N	Fainting spells:	Y / N
Visual defects:	Y / N	Other:	Y / N

Any Recent changes in:

Appetite / Weight	Y / N
Sleep	Y / N
Energy levels	Y / N
Sexual interest / libido	Y / N

Behavioral concerns:

Unusual fears:	Y / N	High activity level	Y / N
Slowed response:	Y / N	Sexual difficulties	Y / N
Destructiveness:	Y / N	Aggressiveness	Y / N
Irritability:	Y / N	Restlessness	Y / N
Excessive sadness:	Y / N	Nightmares	Y / N
Self-destructive:	Y / N	Easily frustrated	Y / N
Stubbornness:	Y / N	Eating problems	Y / N
Sleep problems:	Y / N	Mood swings	Y / N

Suicidal thoughts Y / N Withdrawn Y / N
Isolated Y / N

Problems in driving: _____

Intellectual Concerns:

Difficulty planning or organizing	Y / N
Difficulty in completing activities	Y / N
Difficulty adapting to changes (rigid)	Y / N
Inability to concentrate	Y / N
Easily distracted	Y / N
Impulsive	Y / N
Difficulty learning or remembering	Y / N
Difficulty with comprehension	Y / N
Difficulty with expression	Y / N
Gets lost easily	Y / N
Difficulty with writing	Y / N
Difficulty with reading	Y / N
Difficulty with math	Y / N
Periods of confusion or disorientation	Y / N
Slowed thought processes	Y / N
Changes in mood or personality	Y / N
Change in the way you get along with others	Y / N
Change in social activities	Y / N

Are symptoms staying the same or getting worse? _____

What is your best guess as to why the symptoms are happening? _____

Has daily living at home, work or in social situations been affected by your symptoms?

If yes, describe: _____

What if anything, has helped your symptoms? _____

Please add any additional comments: