BACKGROUND HISTORY QUESTIONNAIRE

Name: _____ Sex M _____ F _____
Address: _____
Home Number: _____Work Number: _____
Cell Number: _____ Email: _____
SSN: _____
Name and Address of Employer: _____
_____
Date of Birth: _____ Age: _____
Ethnicity: _____
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 <u>living with you</u> (the patient) at the present time:

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

How long at current residence? _____

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

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

<u>CURRENT COMPLAINTS</u>

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: