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Background Questionnaire

This questionnaire is intended to help me get an understanding of your experiences and situation, so that I can better help you receive the best possible treatment. Feel free to leave blank any questions which do not apply or which you prefer not to answer in this format. I'll 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 say you have been at for the last few days? _____

Educational/Military Background:

What is the highest school degree you have earned? _____

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:

Dates of service: _____ Type of discharge: _____

Combat experience? _____ Highest rank: _____

Work/Vocational History

What is your current occupation? _____

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, 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 BY
_____	_____	_____
_____	_____	_____

NAME: _____ DATE: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

- continue list on back side of this page if more space is needed -

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

AGENT	DOSAGE	CONDITION/PROBLEM
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- continue list on back side of this page is more space is needed -

Have you ever had major surgery? _____ Yes _____ No

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 103degrees 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 _____

Do you, or have you in the past, regularly used cigarettes or other tobacco products? _____ Yes _____ No

Please list any other medical conditions or concerns: _____

NAME: _____ DATE: _____

Date of last medical examination: _____

Prior experience with psychological treatment

Have you received counseling or psychotherapy previously? _____ 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 conditions/problems: _____

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

Has any one 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 drink alcohol, please describe the type of alcoholic beverages, the amounts, and the frequency:

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

NAME: _____ DATE: _____

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 you birth parents during childhood? Yes No
If "yes", at what age? _____

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: _____

NAME: _____ DATE: _____

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

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.

NAME: _____ DATE: _____

Thank you for taking the time to complete this questionnaire.

Your signature: _____

Reviewed by: _____
Donovan R. Bigelow, J.D., LL.M., M.A.