Initial Evaluation Background Questionnaire Packet

As part of your evaluation, please complete this questionnaire, addressing current difficulties, your goals for the evaluation, and background information. Complete this form before your appointment, and bring it with you to your appointment. This information will be kept confidential.

1. Name (Please print): _____

2. Date of Birth: _____ Age: _____

3. Address: _____
_____

Email: _____

Phone: _____

4. What is the main problem you would like help with?
_____
_____
_____
_____
_____
_____

5. What are your goals for this evaluation (e.g., second opinion, clarify diagnosis, treatment, etc.)?
_____
_____
_____

6. What treatments for this have you tried in the past, if any?
_____
_____
_____
_____

7. What was the most successful treatment, if applicable?
_____
_____
_____

8. When did the current problem begin (i.e., what was going on in your life at the time)?
_____
_____
_____

9. Have you ever received cognitive-behavioral therapy (CBT)?
_____ Yes _____ No _____ Not sure

If yes (or unsure), what did you and your therapist do to work on the problem?

_____

_____

10. Have you ever been hospitalized for psychological problems? If so, please specify the nature of the hospitalization, including when and where.

_____

_____

11. Family and Personal History:

Does any member of your family suffer from alcoholism, epilepsy, depression, anxiety, or anything else that might be considered a mental or nervous system problem? If yes, please describe:

_____

_____

_____

_____

Has any relative ever attempted or committed suicide?

_____

_____

Father: Living _____ Deceased _____
If living, current age: _____ Current health: _____
If deceased, age at time of death: _____
How old were you at the time? _____
Cause of death: _____
Occupation: _____

Mother: Living _____ Deceased _____
If living, current age: _____ Current health: _____
If deceased, age at time of death: _____
How old were you at the time? _____
Cause of death: _____
Occupation: _____

Siblings: Number of brothers:_____ Age(s) of brothers: _____
Number of sisters: _____ Age(s) of sisters: _____
Your place in the family (e.g., 4th of 5 children): _____

Place of birth: _____

As far as you know, did you or your mother experience any health problems during pregnancy or delivery? If yes, please describe: _____

_____

As far as you know, did you meet your developmental milestones on time (e.g., walking or talking)?
Yes _____ No _____ If not, please describe: _____
_____

Many children experience anxiety when separating from their parents (e.g., when going to school). Did you have difficulty with this as a child? _____ Yes _____ No

If yes, did it cause trouble in your life (e.g., significant distress, prevent you from doing things)? Please specify: _____
_____

Many children (and adults) also experience habits such as eye-blinking, nose-twitching, sniffing, throat-clearing, grunting, tapping or touching, or other "tics." As a child, did you experience anything like this? _____ Yes _____ No

What about as an adult? _____ Yes _____ No

If yes, please specify: _____
_____

Were you raised by your parents? Yes _____ No _____

If not, who raised you, and between what ages? _____
_____

Please give a description of your parents' (or parental substitute's) personality and your relationship (past and present): _____
_____

Growing up, how did you get along with your siblings? _____
_____

Please describe your home atmosphere while growing up: _____
_____

Did you experience any significant disruptions while growing up (e.g., prolonged separation from one or both parents, significant geographical move)? _____
_____

If you have a step-parent, please give your age at the time the marriage took place:
_____

Has anyone (parents, relatives, friends) ever interfered with your life (e.g., marriage, occupation, etc.)? _____
_____

12. Education and Occupation:

How far did you go in school?

_____ did not attend high school
_____ some high school
_____ completed high school
_____ some college/university
_____ completed college/university
_____ some graduate school
_____ completed graduate degree

Current Occupation: _____

How long have you been working at your current job? _____

If you are not currently working, please indicate the reason:
_____
_____

What kinds of jobs have you had in the past?
_____
_____

Have you had had difficulty keeping long-term jobs? (If yes, please describe.)
_____
_____

Does your present work satisfy you? _____ Please explain: _____
_____

Have you ever been in the military? If yes, please indicate when and which branch.
_____
_____

13. Current Relationships:

What is your current relationship status? (Please check all that apply.)

_____ Single
_____ In a long-term relationship
_____ Married (Date: _____)
_____ Cohabitating (Date: _____)
_____ Separated (Date: _____)
_____ Divorced (Date: _____)
_____ Widowed (Date: _____)

If married, cohabitating, or in a long-term relationship, what is your partner's age? ____

How long have you been living with/married to your partner? _____

How long have you known each other? _____

What is the last grade completed by your partner or highest degree? _____

What is your partner's current occupation? _____

What words best describe your partner's personality? _____
_____

Please describe the areas in which you are compatible, and the areas in which you are incompatible (e.g., sources of conflict). _____
_____

Please rate your overall level of satisfaction with the relationship. Select a number from 0 to 10, where 0 means very dissatisfied, 5 means neutral, and 10 means very satisfied. Rating: _____

How many children do you have? _____ How many stepchildren? _____

Please give their names, genders, and ages:
_____
_____

Do any of your children present special problems? _____
_____

14. Do you currently have, or have you had in the past, any legal difficulties (other than for minor traffic violations)? If yes, please explain:
_____
_____

Does your current family income feel adequate for your needs? If no, please explain:
_____
_____

15. Religion:

What was your religious background growing up? _____
_____ Practicing _____ Non-practicing

Current religion? _____
_____ Practicing _____ Non-practicing

16. Medication & Biological Factors:

Height _____ Weight _____

When was your last physical exam? Were there any abnormalities?

_____
_____

Do you have any reason to believe you might be pregnant? Yes _____ No _____

Have you ever suffered from or been treated for any of the following?

_____ Heart disease
_____ Cardiac arrhythmias
_____ Angina or chest pain (aside from panic attacks)
_____ High/low blood pressure
_____ Neurological disorder (e.g., epilepsy)
_____ Migraine headaches
_____ Asthma
_____ Other respiratory or chest disease
_____ Thyroid abnormalities
_____ Diabetes
_____ Mitral valve prolapse
_____ Vestibular or inner ear disorder
_____ Contagious blood condition (e.g., hepatitis, HIV/AIDS)

If you answered yes to any of the above, please specify:

_____
_____

Please list ALL current medications (including prescriptions, birth control, over-the-counter medications, and herbal supplements), along with the reason for taking them and the dosage taken:

Medication: Reason: Dose:

_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had a concussion or head injury resulting in loss of consciousness, or which produced any symptoms following the injury? Yes _____ No _____
If yes, please specify: _____

Have you ever had any operations or surgeries? Yes _____ No _____
If yes, please specify: _____

Have you experienced any of the following in the past year (aside from during panic attacks or elevated anxiety)?

_____ Convulsions
_____ Frequent or chronic cough
_____ Chest pain or angina pectoris
_____ Spitting up blood
_____ Night sweats
_____ Severe shortness of breath (on exertion or at night)
_____ Palpitations or irregular heartbeat
_____ Swelling of hands, feet, or ankles
_____ Abnormal thirst
_____ Abnormal blood or urine test

If you answered yes to any of the above, please specify:
_____
_____

Please list any allergies you may have:
_____
_____

Are there any medical problems that haven't been covered by above questions? If yes, please specify:
_____
_____
_____

17. Is there any other information that we did not ask you about that would be important for us to know?
_____
_____
_____
_____
_____