The Nicholls Group

Background History Form

We have learned that it is hard to remember everything you want to tell us when you are sitting in our offce. We want to know as much as we can about your concerns and living circumstances, and have found that asking many of our questions ahead of your visit makes it easier for everyone involved. Please answer the following questions to the best of your ability. Some of the items will probably not apply to your situation, however we live in diverse world and hope to not overlook possibilities. The more you tell us, the better the job we can do to address your concerns. If a section of the questionnaire doesn't apply to you (for example occupational history for a child), or if you prefer to not answer any questions that's ok - just skip to the next one!

PATIENT/PRIMARY CLIENT'S INFORMATION

Patient Name*

Date of Birth*

Email*

Home Address*

City*

State*

Zip Code*

Primary Phone*

Phone Type*

Secondary Phone

Phone Type

Please provide us with appropriate email addresses - we will never share them with others without your permission

Email Address 1*

Name 1*

Relationship 1*

Email Address 2

Name 2

Relationship 2

Email Address 3

Name 3

Relationship 3

Email Address 4

Name 4

Relationship 4

INFORMATION REGARDING IMPORTANT PERSONS IN THE PRIMARY PATIENT'S LIFE

Important person #1*

Contact phone number*

Relationship*

○ Parent ○ Spouse/Partner ○ Guardian ○ Other

☐ Same as patient address

Address*

City*

State*

Zip Code*

☐ If different than above

Important Person #2

Contact Phone Phone

Relationship

○ Parent ○ Spouse/Partner ○ Guardian ○ Other

Address

City

State

Zip Code

PLEASE LIST YOUR CONCERNS AND REASONS FOR SEEKING SERVICES

Please list your concerns and reasons for seeking services

Please tell us specifically what you would like to have happen in coming to our office

☐ Looking for consultation/advice/education

☐ Looking for an evaluation

☐ Looking for individual therapy/counseling

☐ Looking for family therapy/counseling

☐ Looking for referral

☐ Other

What are your specific concerns

CURRENT STATUS OF PATIENT

At the present time, the patient's health is:

At the present time the patient's sleeping pattern involves:

Has the patient ever been bullied? ○ No ○ Yes

Has the patient ever been abused? ○ No ○ Yes

Has the patient ever been arrested or in legal trouble? ○ No ○ Yes

Is the patient using alcohol or recreational drugs to excess? ○ No ○ Yes

Are there any concerns regarding the patient's sexual behavior? ○ No ○ Yes

Are there any concerns regarding the patient's driving? ○ No ○ Yes

Does the patient have any of the following troubles?

	Not at all	Somewhat	A Lot
Fidgets	○	○	○
Difficulty remaining seated	○	○	○
Difficulty playing quietly	○	○	○
Often talks excessively	○	○	○
Runs about or climbs excessively	○	○	○
On the go or acts as if driven by a motor	○	○	○
Difficulty awaiting turn	○	○	○
Often blurts out answers to questions before completed	○	○	○
Often interrupts or intrudes on others	○	○	○
Often engages in physically dangerous activities	○	○	○
Difficulty following instructions	○	○	○
Difficulty sustaining attention	○	○	○
Shifts from one activity to another	○	○	○
Often does not listen	○	○	○
Often loses things	○	○	○
Easily distracted	○	○	○
Gives up easily	○	○	○
Inconsistent performance	○	○	○
Poor motivation	○	○	○
Disorganized	○	○	○
Doesn't finish tasks	○	○	○
Low frustration tolerance	○	○	○
Poor handwriting	○	○	○
Mood swings	○	○	○
Often loses temper	○	○	○
Often argues with adults	○	○	○
Often actively defies or refuses adult requests or rules	○	○	○
Often deliberately does things that annoy other people	○	○	○
Often blames others for own mistakes	○	○	○
Is often touchy or easily annoyed by others	○	○	○
Is often angry or resentful	○	○	○
Is often spiteful or vindictive	○	○	○
Often swears or uses obscene language	○	○	○
Depressed or irritable mood most of day, nearly every day	○	○	○
Diminished pleasure in activities	○	○	○
Agitation or sluggishness	○	○	○
Feelings of worthlessness or excessive inappropriate guilt	○	○	○
Poor appetite or overeating	○	○	○

Trouble sleeping or sleeps too much	○	○	○
Low self-esteem	○	○	○
Poor concentration or difficulty making decisions	○	○	○
Feelings of hopelessness	○	○	○
Repeated unusual movements	○	○	○
Odd postures	○	○	○
Excessive reaction to noise or fails to react to loud noises	○	○	○
Overreacts to touch	○	○	○
Compulsive rituals	○	○	○
Motor tics	○	○	○
Vocal tics	○	○	○
Can’t get to the point, loses train of thought	○	○	○
Bizarre ideas (e.g., odd fascinations, strange ideas, hallucinations)	○	○	○
Disoriented, confused, staring, or “Spacy”	○	○	○
Incoherent speech (mumbles, uses words only child understands)	○	○	○
Excessive mood swings	○	○	○
Explosive temper with minimal provocation	○	○	○
Excessive clinging, attachment, or dependence on adults	○	○	○
Unusual fears, repetitive worries	○	○	○
Panic attacks	○	○	○
Excessively monotonous or bland affect	○	○	○
Situationally inappropriate emotions	○	○	○
Little or no interest in peers or friends	○	○	○
Significant indiscreet remarks	○	○	○
Initiates or terminates interactions inappropriately	○	○	○
Abnormal social behavior	○	○	○
Excessive reaction to changes in routine	○	○	○

EARLY HISTORY

The following questions help us to understand the patient's growth and development, which is sometimes useful in understanding their current situation. Many of the items may not apply, or may be hard to remember, but please give us as much information as you can!

Please tell us about the patient's conception:

☐ Fertility drug usage? ☐ Artificial insemination? ☐ A donor egg?
☐ A donor sperm? ☐ Sperm injection? ☐ In vitro fertilization?
☐ Donor embryo? ☐ Reproductive surgery? ☐ Gamete/Zygote intrafallopian transfer?
☐ Surrogacy?

How old was mother at the time the child was born?

How old was father at the time the child was born?

How many prior pregnancies did mother have?

How many prior miscarriages did mother have?

What health problems did mother have during pregnancy?

☐ Vaginal bleeding ☐ Toxemia ☐ Hypertension/high blood pressure
☐ Gestational diabetes ☐ Trauma ☐ Fever/rash (e.g. flu, meningitis)
☐ Seizure ☐ Excessive nausea and vomiting ☐ Smoking
☐ Alcohol ☐ Illicit drugs

What medicines did mother take during her pregnancy?

How long did the pregnancy last?

How was the baby delivered?

How much did the baby weigh at birth?

How long did labor last?

Were there any complications of the delivery?

Did the baby need oxygen at birth?

Was the baby taken to an Intensive Care Nursery immediately after birth?

Do you know the baby's Apgar scores?

Time	Score
1 minute	
5 minutes	
10 minutes	

If the baby needed intensive care, how old was he/she when discharg

Was the baby placed on a breathing machine?

Did the baby have any brain problems in the NICU?

Did the baby have serious infections or a need for antibiotics in the NICU?

Were there other problems experienced by the baby at birth?

After the baby was discharged from the hospital, were there any problems with:

Did birth mother have any post-partum depression?

Did birth mother have ongoing medical problems that interfered with caring for the baby?

Did baby get discharged to birth mother?

Infancy and Early Childhood

Please describe you child's temperament:

Quiet and content	○1	○2	○3	○4	○5	Colicky and irritable
Very easy to feed	○1	○2	○3	○4	○5	Daily feeding problems
Slept well	○1	○2	○3	○4	○5	Frequent sleeping problems
Usually relaxed	○1	○2	○3	○4	○5	Often restless
Underactive	○1	○2	○3	○4	○5	Overactive
Cuddly, easy to hold	○1	○2	○3	○4	○5	Did not enjoy cuddling
Easily calmed down	○1	○2	○3	○4	○5	Hard to calm down
Cautious and careful	○1	○2	○3	○4	○5	Adventurous and impulsives
Coordinated	○1	○2	○3	○4	○5	Uncoordinated/clumsy
Enjoyed eye contact	○1	○2	○3	○4	○5	Avoided eye contact
Liked people	○1	○2	○3	○4	○5	Disliked contact with people

Other problems or comments regarding infancy or early childhood development:

Did any event, health condition, separation, etc., disturb early infant/parent bonding or the developing toddler/mother relationship?

How was the patient's early development?

○ I don't know or can't remember
○ I don't remember exactly but overall it seemed
  ○ Advanced
  ○ Normal
  ○ Delayed
○ I remember ages for

Sitting		Crawling		Walking		Well-coordinated	
Self-feeding		Scribbling		Tied shoes		Babbling	
First words		Sentences		Good use of language		Toileting during the day	
Toileting at night							

Please tell us anything that you want us to know that hasn't been covered in this questionnaire:

EDUCATIONAL HISTORY

Did the patient attend preschool or daycare?

Current grade and school

List previous schools and grades attended at each:

Briefly describe the primary patients performance and any concerns in each grade:

Kindergarten

1st grade

2nd grade

3rd grade

4th grade

5th grade

Middle School

High School

Has the primary patient received special education programs currently or in the past? ○ No ○ Yes

Category

Learning Disability (LD): Subjects

Language Disorder: Type

Speech/Language/Occupational Therapy:

Other:

Tutoring: Subjects

Has the patient graduated from high school? ○ No ○ Yes

Has the patient obtained a GED? ○ No ○ Yes

Has the patient completed any certificate programs? ○ No ○ Yes

Has the patient attended any college or graduate schooling?

○ Has taken some college courses but has not achieved a degree

○ Has an Associate's Degree with an emphasis in

○ Has a Bachelor's Degree with a major in

○ Has a Master's Degree in

○ Has a Doctoral Degree in

Please list the names of any colleges or graduate programs attended:

HEALTH INFORMATION AND HISTORY

Who is the physician that the primary patient usually visits?

When did the primary patient last have a physical examination?

Please indicate which of the following the primary patient is currently experiencing or has experienced in the past:

- ☐ asthma
- ☐ arthritis
- ☐ anemia
- ☐ headaches
- ☐ cancer
- ☐ stroke
- ☐ allergies
- ☐ fertility difficulties
- ☐ eating disorder
- ☐ heart attack
- ☐ heart disease
- ☐ diabetes
- ☐ ulcer
- ☐ alcohol addiction
- ☐ drug addiction
- ☐ chronic illness
- ☐ sexual difficulties
- ☐ hospitalization
- ☐ nicotine addition
- ☐ concussion (head injury)
- ☐ poison ingestion
- ☐ surgery
- ☐ respiratory difficulties
- ☐ digestive difficulties
- ☐ obesity
- ☐ high blood pressure
- ☐ seizures
- ☐ chronic pain
- ☐ ear infections
- ☐ other injuries/medical diseases:

Is the primary patient currently taking any medications?

○ Yes ○ No

Please list all medication the primary patient is currently taking (prescribed or over the counter):

#	Medication	Dosage	For what reason
1			
2			
3			

Additional medications or medical treatments:

Please check which of the following physical complaints the primary patient is currently experiencing:

- ☐ sleeping difficulties
- ☐ dizziness
- ☐ increased/decreased appetite
- ☐ increased heart rate
- ☐ restlessness
- ☐ chest pain or discomfort
- ☐ breathing difficulties
- ☐ drowsiness
- ☐ frequent muscle pain
- ☐ frequent stomach aches
- ☐ fatigue
- ☐ discomfort during sex
- ☐ other:

Please tell us about any surgeries the primary patient has had:

Does the primary patient currently have any of the following concerns?

Vision trouble

- ☐ Can't see/legally blind
- ☐ Trouble seeing far away
- ☐ Trouble seeing up close
- ☐ Poor vision in one eye
- ☐ Double vision
- ☐ Color blind
- ☐ Poor nighttime vision
- ☐ Macular degeneration or other eye disease
- ☐ Wears glasses/contacts disease

Hearing trouble

- ☐ Can't hear/deaf
- ☐ Wears hearing aids/implants
- ☐ High frequency hearing problems (affects ur
- ☐ Chronic ear infections
- ☐ Ringing in ears

Other sensory trouble

- ☐ Poor sense of taste/smell
- ☐ Poor sense of touch
- ☐ Poor sense of body position
- ☐ Loss of sensation (please clarify where and if known, why)

Movement difficulty

- ☐ Trouble walking
- ☐ Trouble talking
- ☐ Trouble using hands
- ☐ Uncoordinated/clumsy
- ☐ Poor balance
- ☐ Frequent falls
- ☐ Poor handwriting

Ongoing medical illness associated with:

- ☐ Eating
  - ☐ Too much
  - ☐ Overweight
  - ☐ Too little
  - ☐ Underweight
  - ☐ Food intolerances
  - ☐ Food allergies
- ☐ Stomach/gastrointestinal troubles
  - ☐ Nausea/vomiting
  - ☐ Stomachaches
  - ☐ Jaundice
  - ☐ Ulcers
  - ☐ Reflux
- ☐ Heart/blood troubles
  - ☐ Chest pains
  - ☐ Fainting spells
  - ☐ Swelling of ankles
  - ☐ Heart murmur
  - ☐ High blood pressure
  - ☐ Low blood pressure
- ☐ Urine/bowel problems
  - ☐ Bladder accidents
    - ☐ Nighttime ☐ Daytime
  - ☐ Bowel accidents
    - ☐ Nighttime ☐ Daytime
  - ☐ Constipated
  - ☐ Diarrhea
- ☐ Breathing troubles
  - ☐ Allergies/Asthma
  - ☐ Short of breath
  - ☐ Wheezing
  - ☐ Frequent coughing
  - ☐ Chronic lung disease
  - ☐ Needs/uses oxygen during day
- ☐ Neurological/brain troubles
  - ☐ Loss of strength
  - ☐ Numbness
  - ☐ Tremors
  - ☐ Memory loss
  - ☐ Has seizures
- ☐ Sexual troubles
  - ☐ Erectile dysfunction
  - ☐ Premature ejaculation
- ☐ Sleeping troubles
  - ☐ Sleeps too little
  - ☐ Sleeps too much
  - ☐ Bedtime troubles
  - ☐ Frequent awakening
  - ☐ Wakes up too early
  - ☐ Trouble waking up
  - ☐ Snores
  - ☐ Night terrors/nightmares
  - ☐ Needs/uses oxygen at night
  - ☐ Needs/uses cpap or other breathing aid at
- ☐ Endocrine/gland troubles
  - ☐ Loss of hair
  - ☐ Heat/cold intolerance
- ☐ Skin troubles
  - ☐ Has been badly burned
  - ☐ Has hives/eczema/skin rashes

☐Rapid heartbeat
☐Slow heartbeat
☐Irregular heartbeat
☐Has had a heart attack
☐Has had a stroke
☐Poor circulation/cold feet/hands

☐Bone/joint/muscle troubles
☐Pain/swelling
☐Stiffness
☐Muscle pain
☐Arthritis
☐Broken bones
☐Other bone/joint/muscle diseases

☐Has headaches
☐Has had stroke or "TIA"
☐Has brain disease/illness
☐Other

☐Has skin cancers
☐Other skin disease

☐Diabetes/blood sugar troubles
☐Hypoglycemia/blood sugar too low
☐Hyperglycemia/diabetes
☐Takes/needs insulin?

What substances has the patient either previously or currently used:

☐cigarettes ☐Current Use ☐Past Use
☐cocaine ☐Current Use ☐Past Use
☐amphetamines ☐Current Use ☐Past Use
☐ecstasy ☐Current Use ☐Past Use
☐mushrooms ☐Current Use ☐Past Use
☐inhalants (glue, paint, etc.) ☐Current Use ☐Past Use

☐alcohol ☐Current Use ☐Past Use
☐caffeine ☐Current Use ☐Past Use
☐meth/crystal ☐Current Use ☐Past Use
☐acid (LSD) ☐Current Use ☐Past Use
☐PCP ☐Current Use ☐Past Use

☐heroin/opiates/pain pills ☐Current Use ☐Past Use
☐marijuana ☐Current Use ☐Past Use
☐barbiturates/tranquilizers ☐Current Use ☐Past Use
☐steroids ☐Current Use ☐Past Use
☐peyote ☐Current Use ☐Past Use

FAMILY ARRANGEMENT

Please tell us who else is living in the household:

Person #	Name	Age	Relationship to primary patient
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

If the primary patient is a child/adolescent/young adult living with parents/guardians,

- ○ Both biological parents living together
- ○ Both biological parents living in different houses
  - ○ Biological mother alone
  - ○ Biological mother and partner
  - ○ Biological father alone
  - ○ Biological father and partner
  - ○ Alternative arrangement
    - ○ Adoptive parent(s)
    - ○ Grandparent(s) parent(s)
    - ○ Other relative(s)
    - ○ Other guardian

Current status of child's parents' marriage:
○ Married ○ Separated ○ Widowed
○ Single ○ Divorced ○ Never Married

Length of time of marriage of biological parents:

Who has legal custody of child?
○ Both parents ○ Mother ○ Father ○ Other

Child's age at the time of divorce:

PARENTS HISTORY

Complete those that apply:

	Birth Mother	Birth Father
Age		
Highest grade completed/degree		
Occupation		
Special Education		
Repeated a grade		
Learning Disability		
Attention-Deficit/Hyperactivity Disorder		
Speech/Language difficulty		
Psychiatric history		

	Nonbiological caregiver #1	Nonbiological caregiver #2
Age		
Highest grade completed/degree		
Occupation		
Special Education		
Repeated a grade		
Learning Disability		
Attention-Deficit/Hyperactivity Disorder		
Speech/Language difficulty		
Psychiatric history		

Other Children (including step-siblings and half-siblings)

Name	Age	M/F	Living at home?	School/behavioral/health problems?

Please tell us about any medical, cognitive or psychiatric troubles within your extended family (including grandparents, aunts/uncles, cousir
☐ learning problems ☐ emotional/psychiatric problems ☐ neurological problems ☐ interpersonal problems

Please tell us about any religious or cultural considerations that you feel are important for us to know in working with you.

OCCUPATIONAL HISTORY

Primary Patient's current occupation

How long has primary patient held this job?

How satisfied is the primary patient with his/her job?

Previous jobs

If retired, year of retirement

What is primary patients current job duties / requirements?

What is the primary patients job title or role?

Has the primary patient experiencing any troubles at work? ○ No ○ Yes

Has the primary patient been fired from any jobs? ○ No ○ Yes

MILITARY HISTORY

Has the primary patient served in the military? ○ No ○ Yes

Was the primary patient ever in combat? ○ No ○ Yes

Was the primary patient ever injured? ○ No ○ Yes