



Background History Form

We have learned that it is hard to remember everything you want to tell us when you are sitting in our office. 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*
<input type="text"/>	<input type="text"/>

Email*
<input type="text"/>

Home Address*	City*	State*	Zip Code*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Phone*	Phone Type*	Secondary Phone	Phone Type
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Email Address 1*	Name 1*	Relationship 1*
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email Address 2	Name 2	Relationship 2
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email Address 3	Name 3	Relationship 3
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email Address 4	Name 4	Relationship 4
<input type="text"/>	<input type="text"/>	<input type="text"/>

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:

Has the patient ever been bullied? No Yes

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

Are there any concerns regarding the patient's sexual behavior?

No Yes

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

Has the patient ever been abused? No Yes

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

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

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:

- | | | |
|------------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Fertility drug usage? | <input type="checkbox"/> Artificial insemination? | <input type="checkbox"/> A donor egg? |
| <input type="checkbox"/> A donor sperm? | <input type="checkbox"/> Sperm injection? | <input type="checkbox"/> In vitro fertilization? |
| <input type="checkbox"/> Donor embryo? | <input type="checkbox"/> Reproductive surgery? | <input type="checkbox"/> Gamete/Zygote intrafallopian transfer? |
| <input type="checkbox"/> 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?

- | | | |
|-----------------------------------------------|--------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Hypertension/high blood pressure |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Trauma | <input type="checkbox"/> Fever/rash (e.g. flu, meningitis) |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Excessive nausea and vomiting | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> 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?

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

Time	Score
1 minute	
5 minutes	
10 minutes	

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 your child's temperament:

Quiet and content	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Colicky and irritable
Very easy to feed	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Daily feeding problems
Slept well	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Frequent sleeping problems
Usually relaxed	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Often restless
Underactive	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Overactive
Cuddly, easy to hold	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Did not enjoy cuddling
Easily calmed down	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Hard to calm down
Cautious and careful	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Adventurous and impulsive
Coordinated	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Uncoordinated/clumsy
Enjoyed eye contact	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	Avoided eye contact
Liked people	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	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	<input type="text"/>	Crawling	<input type="text"/>	Walking	<input type="text"/>	Well-coordinated	<input type="text"/>
Self-feeding	<input type="text"/>	Scribbling	<input type="text"/>	Tied shoes	<input type="text"/>	Babbling	<input type="text"/>
First words	<input type="text"/>	Sentences	<input type="text"/>	Good use of language	<input type="text"/>	Toileting during the day	<input type="text"/>
Toileting at night	<input type="text"/>						

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:

- | | | |
|-----------------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> arthritis | <input type="checkbox"/> anemia |
| <input type="checkbox"/> headaches | <input type="checkbox"/> cancer | <input type="checkbox"/> stroke |
| <input type="checkbox"/> allergies | <input type="checkbox"/> fertility difficulties | <input type="checkbox"/> eating disorder |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> heart disease | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> ulcer | <input type="checkbox"/> alcohol addiction | <input type="checkbox"/> drug addiction |
| <input type="checkbox"/> chronic illness | <input type="checkbox"/> sexual difficulties | <input type="checkbox"/> hospitalization |
| <input type="checkbox"/> nicotine addition | <input type="checkbox"/> concussion (head injury) | <input type="checkbox"/> poison ingestion |
| <input type="checkbox"/> surgery | <input type="checkbox"/> respiratory difficulties | <input type="checkbox"/> digestive difficulties |
| <input type="checkbox"/> obesity | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> seizures |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> ear infections | |
| <input type="checkbox"/> 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:

- | | | |
|-------------------------------------------------|---------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> sleeping difficulties | <input type="checkbox"/> dizziness | <input type="checkbox"/> increased/decreased appetite |
| <input type="checkbox"/> increased heart rate | <input type="checkbox"/> restlessness | <input type="checkbox"/> chest pain or discomfort |
| <input type="checkbox"/> breathing difficulties | <input type="checkbox"/> drowsiness | <input type="checkbox"/> frequent muscle pain |
| <input type="checkbox"/> frequent stomach aches | <input type="checkbox"/> fatigue | <input type="checkbox"/> discomfort during sex |
| <input type="checkbox"/> 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

- | | | |
|--------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Can't see/legally blind | <input type="checkbox"/> Trouble seeing far away | <input type="checkbox"/> Trouble seeing up close |
| <input type="checkbox"/> Poor vision in one eye | <input type="checkbox"/> Double vision | <input type="checkbox"/> Color blind |
| <input type="checkbox"/> Poor nighttime vision | <input type="checkbox"/> Macular degeneration or other eye disease | <input type="checkbox"/> Wears glasses/contacts disease |

Hearing trouble

- | | | |
|-------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Can't hear/deaf | <input type="checkbox"/> Wears hearing aids/implants | <input type="checkbox"/> High frequency hearing problems (affects un |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Ringing in ears | |

Other sensory trouble

- | | | |
|-------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Poor sense of taste/smell | <input type="checkbox"/> Poor sense of touch | <input type="checkbox"/> Poor sense of body position |
| <input type="checkbox"/> Loss of sensation (please clarify where and if known, why) | | |

Movement difficulty

- | | | |
|-----------------------------------------------|------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Trouble walking | <input type="checkbox"/> Trouble talking | <input type="checkbox"/> Trouble using hands |
| <input type="checkbox"/> Uncoordinated/clumsy | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Frequent falls |
| <input type="checkbox"/> Poor handwriting | | |

Ongoing medical illness associated with:

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

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> cigarettes <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> cocaine <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> amphetamines <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> ecstasy <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> mushrooms <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> inhalants (glue, paint, etc.) <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use | <ul style="list-style-type: none"> <input type="checkbox"/> alcohol <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> caffeine <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> meth/crystal <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> acid (LSD) <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> PCP <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use | <ul style="list-style-type: none"> <input type="checkbox"/> heroin/opiates/pain pills <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> marijuana <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> barbiturates/tranquilizers <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> steroids <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> Past Use <input type="checkbox"/> peyote <ul style="list-style-type: none"> <input type="checkbox"/> Current Use <input type="checkbox"/> 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

Who has legal custody of child?

- Both parents Mother Father Other

Length of time of marriage of biological parents:

Child's age at the time of divorce:

PARENTS HISTORY

Complete those that apply:

	Birth Mother	Birth Father
Age	<input type="text"/>	<input type="text"/>
Highest grade completed/degree	<input type="text"/>	<input type="text"/>
Occupation	<input type="text"/>	<input type="text"/>
Special Education	<input type="text"/>	<input type="text"/>
Repeated a grade	<input type="text"/>	<input type="text"/>
Learning Disability	<input type="text"/>	<input type="text"/>
Attention-Deficit/Hyperactivity Disorder	<input type="text"/>	<input type="text"/>
Speech/Language difficulty	<input type="text"/>	<input type="text"/>
Psychiatric history	<input type="text"/>	<input type="text"/>

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

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

Name	Age	M/F	Living at home?	School/behavioral/health problems?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please tell us about any medical, cognitive or psychiatric troubles within your extended family (including grandparents, aunts/uncles, cousins)

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