ADULT BACKGROUND QUESTIONNAIRE

Name: _____ Today's date: _____

Birth date: _____ Last 4 digits of Social Security #: _____

Age: _____ Gender: _____ Ethnicity: _____

Current address: _____ City: _____ State: ____ Zip:_____

Mailing address: _____ City: _____ State: _____ Zip:_____

Marital Status: Married Single Separated Divorced Widowed

Current Height: _____ Current Weight: _____ Handedness: R _____ L _____

Current Occupation: _____ Household Income Range: _____

Year in school (if applicable): _____

List all people living in household:

Name	Age	Relationship	Describe Relationship

Primary language spoken in the home: _____

Other languages spoken in the home: _____

PRESENTING PROBLEMS

Briefly describe your current difficulties: _____
_____
_____
_____
_____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____
_____
_____

What seems to help the problem? _____
_____
_____

What seems to make the problem worse?_____
_____
_____

Does the problem occur more often in certain settings?_____
_____
_____

Have you received an evaluation or treatment (i.e., therapy) for the current or similar problems? Yes ____No _____

If yes, when and with whom? _____
_____
_____

Was treatment effective? Yes _____ No _____

What did you like best about the treatment? _____
_____
_____

What did you like least about the treatment? _____
_____
_____

Have you ever received a mental health diagnosis? Yes _____ No _____
If yes, what diagnoses and when? _____
_____

Are you currently taking any medication at this time? Yes _____ No _____
If yes, please note kind of medication below:

_____
_____
_____
_____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that you currently exhibits/experience.

_____ Difficulty with speech

_____ Difficulty with hearing

_____ Difficulty with language

_____ Poor hygiene

_____ Difficulty with vision

_____ Difficulty with coordination

_____ Interpersonal problems

_____Prefers to be alone

_____ Do you get along well with others

_____ Anger/Aggression

_____ Shy or timid

_____ More interested in things (objects) than in people

_____ Engage in behavior that could be dangerous to self

_____ Special fears, habits, or mannerisms (describe) _____

_____ Engage in daredevil or risky behavior

_____ Give up easily

_____ Express/Experience frequent worry or concern

_____ Bite nails

_____ See or hear things that others don't

_____ Irritable

_____ Frequent tantrums

_____ Frequent nightmares

_____ Difficulty sleeping (describe)_____

_____ Unusual sleep patterns

_____ Blank staring spells

_____ Engage in self-soothe behavior (specify) _____

_____ Anxious

_____ Depression/Sadness (specify) _____

_____ Eat poorly/Poor diet

_____ Stubborn

_____ Over-active

_____ Impulsive

_____ Fidgety

_____ Slow to learn

_____ Obsess over specific thoughts (specify) _____

_____ Pick at own skin/pulls hair

_____ Self-injurious behavior

_____ Contemplated/attempted suicide

Other (please described): _____
_____
_____
_____
_____
_____

EDUCATIONAL HISTORY

Place a check next to any educational problems that you currently exhibit

_____ Difficulty with reading

_____ Difficulty with math

_____ Difficulty with spelling

_____ Difficulty with writing

_____ Do not like school

_____ Failing classes

_____ Difficulty with other subjects

(please list) _____
_____
_____

_____ Refuse to attend school

_____ Frequent absences

_____ Low motivation

Academic strengths:_____
_____
_____

Have you ever been diagnosed with a learning disability? Yes _____ No _____

If yes, please explain. _____
_____
_____

Do you currently have an Individualized Education Plan (IEP)? Yes _____ No _____

If yes, please provide any details about the IEP that you can. _____
_____

Have you ever been held back in school? Yes _____ No _____

If yes, what grade and why? _____

Have you ever received special tutoring or therapy in school? Yes _____ No _____

If yes, please describe. _____

What are your most recent grades? _____
_____

Have your grades changed in recent years (either improved or worsened)? Yes _____ No _____

If yes, please describe. _____
_____
_____
_____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes_____ No _____If yes, what kind? _____

During pregnancy, did mother smoke? Yes _____ No _____ If yes, how many cigarettes each day? _____

During pregnancy, did mother drink alcoholic beverages? Yes _____ No _____ If yes, what did she drink? _____

Approximately how much alcohol was consumed each day?_____

During pregnancy, did mother use drugs? Yes _____ No _____ If yes, what kind? _____

Was a Cesarean section performed? Yes _____ No _____. If yes, for what reason? _____

Were you born premature? Yes _____ No _____ If so, by how many months? _____

What was your birth weight? _____ What was your birth length? _____

Were there any birth defects or complications? Yes _____ No _____ If yes, please describe. _____

Were there any feeding problems? Yes _____ No _____ If yes, please describe. _____

Were there any sleeping problems? Yes _____ No _____ If yes, please describe. _____

As an infant, did you cry excessively? Yes _____ No _____

If yes, describe. _____

As an infant, were you hard to comfort? Yes _____ No _____

As an infant, did you like to be held? Yes _____ No _____

As an infant, were you alert? Yes _____ No _____

As a baby, did you demonstrate a range of emotions? Yes _____ No _____

Were there any special problems during the first few years of your growth and development? Yes ____ No____

If yes, please describe. _____

As a toddler, did you seek you out to share in play and enjoyment? Yes ____ No _____

The following is a list of infant and preschool behaviors. Please indicate any that were preformed outside of normal developmental limits (i.e., early or late). Please estimate as best as possible.

Behavior	Age	Behavior	Age
Showed response to parent	_____	Spoke first word	_____
Rolled over	_____	Put several words together	_____
Sat alone	_____	Dressed self	_____
Crawled	_____	Became toilet trained	_____
Walked alone	_____	Stayed dry at night	_____
Babbled	_____	Fed self	_____

MEDICAL HISTORY

Place a check next to any illness or condition that you have had. When you check an item, also note the approximate date (or age) of the illness.

	Illness or condition	Date(s) or Age(s)		Illness or condition	Date(s) or Age(s)
_____	Measles	_____	_____	Dizziness	_____
_____	Mumps	_____	_____	Difficulty concentrating	_____
_____	Chicken Pox	_____	_____	Memory problems	_____
_____	Whooping cough	_____	_____	Extreme tiredness or Weakness	_____
_____	Meningitis	_____	_____	Epilepsy	_____
_____	Encephalitis	_____	_____	Convulsions	_____
_____	High fever	_____	_____	Seizures	_____
_____	Allergy	_____	_____	Frequent/Severe headaches	_____
_____	Injuries to head	_____	_____	Diabetes	_____
_____	Broken bones	_____	_____	Cancer	_____
_____	Hospitalizations	_____	_____	High blood pressure	_____
_____	Operations Describe: _____	_____	_____	Heart disease	_____
_____	Asthma	_____	_____	Paralysis	_____
_____	Fainting Spells	_____	_____	Loss of consciousness	_____
_____	Other: _____				

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of your family has had.

	Condition	Relationship		Condition	Relationship
_____	Alcoholism	_____	_____	Depression	_____
_____	Schizophrenia	_____	_____	Learning disability	_____
_____	Bipolar Disorder	_____	_____	ADHD	_____
_____	Anxiety Disorder	_____	_____	Intellectual Disability	_____

Other/Additional Information: _____
_____
_____

OTHER INFORMATION

What are your favorite activities?

1._____ 2._____ 3._____

4._____ 5._____ 6._____

What activities would you like to engage in more often than you do at present?

1._____ 2._____ 3._____

What activities do you like least?

1._____ 2._____ 3._____

Have ever been in trouble with law? Yes _____ No _____

If yes, please describe briefly. _____
_____
_____

What would you identify as your assets or strengths?
_____
_____
_____

Is there any other information you would like to share at this time?
_____
_____
_____
_____
_____

Please provide any additional questions or concerns below:
_____
_____
_____
_____
_____
_____