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Background Questionnaire
The following is a detailed questionnaire on your development, medical history, and current functioning at home and at work. Please fill out the questionnaire as completely as you can.

Today's Date:_____
Name:_____
If not the client, the name of the person completing the form:_____
Relationship to the client:_____
Client's home address (street city and zip code):
_____
Client Phone: (home)_____ Cell:_____Work:_____
Date of Birth:_____ Age:_____ Gender: _____
Place of Birth:_____
Primary Language:_____ Secondary Language:_____
Hand used for writing: _____ Right _____ Left

**PERSONAL HISTORY**
Marital History
Current marital status: (circle)
Single Married Common-Law Separated Divorced Widowed
Years married to current spouse:_____
Spouse's name:_____
Spouse's occupation:_____
Spouse's health: Excellent Good Poor
Dates of previous marriages: From _____ to _____ From_____to_____
Children

| Name | Age | Gender | Occupation | Indicate Biological/Adopted/Step |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Who currently lives in the home?_____
_____

Do any family members have significant health concerns/special needs? (describe)
_____
_____

Educational history:
Highest level of education achieved: (circle)
High school College Trade school Graduate School

Name and location of High School:

Name and location of college or trade school:

Were any grades repeated? ___Yes ___No Which ones?_____
Reason?_____
Were there any special problems learning to read, write, or do
math?_____
_____

Were you ever in any special class(es) or did you ever receive special services? ___Yes ___No
If yes, what grade(s) or age(s)?_____
What type of class or services?_____
What type of grades did you typically receive? What comments were made by your instructors about your success?_____

Military Service
Did you ever serve in the military or special forces? ___Yes ___No
If yes, which branch?_____ Dates:_____
Duties_____
Did you serve time in war? ___Yes ___No
If yes, in what arena?_____
Did you receive injuries or were you exposed to any dangerous or unusual substance during your service? ___Yes ___ No If yes, please describe:

Occupational History
Are you currently working? ___Yes ___No
Current job title:_____
Name of employer:_____
Current responsibilities:_____
Dates of employment:_____
Are you currently experiencing any problems at work? ___Yes ___ No
If yes, please describe:_____
Do you see your current work situation as stable? ___Yes ___No
Approximate income:_____

Previous employers and reason(s) for leaving:

Recreation
List the types of recreation and/or leisure that you enjoy:

What are your personal strengths?

Have others commented to you about changes in your thinking, behavior, personality, or mood? Describe:

Are you experiencing problems in the following aspects of your life? Please explain:
Marital/Family:

Financial/Legal:

Housekeeping/Money Management:

Driving:

Overall my symptoms have developed: slowly quickly

My symptoms occur: occasionally often

Over the last 6 months my symptoms have:
improved stayed the same worsened

What makes the problems better?

What makes the problems worse?

**EARLY HISTORY**

Your birth was: on time premature late
Your weight at birth: _____ Your height at birth: _____

Were there any problems associated with your birth (e.g. lack of oxygen, unusual birth position) or the period after your birth (e.g. need for oxygen, jaundice, convulsions, illness)? Please describe:

Check all that applied to your mother while she was pregnant with you:
_____accident
_____alcohol use
_____Cigarette smoking
_____drug use (marijuana, cocaine, LSD, etc)
_____Illness (tomemia, diabetes, high blood pressure, infection, etc.)
_____poor nutrition
_____psychological problems
_____medications
_____other problems_____

List any medications that your mother took while pregnant with you:

Rate your developmental progress (as it has been reported to you) by checking the appropriate box:

| | Early | Average | Late |
|---|---|---|---|
| Walking | | | |
| Language | | | |
| Toilet Training | | | |
| Overall development | | | |

As a child did you have any of the following? (Circle any that apply)

| | |
|---|---|
| Attentional problems | Learning disability |
| Clumsiness | Speech problems |
| Developmental delay | Hearing problems |
| Hyperactivity | Frequent ear infections |
| Muscle weakness | Visual problems |

**MEDICAL HISTORY**

List all medical providers associated with your care:

_____
_____
_____

Medical Diagnosis _____
_____
_____
_____

List **ALL** medications currently using:

| Medication | Reason taking | Dosage | Start date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

List all hospitalizations, including the name of the hospital, approximate dates of stay, and diagnosis:

Medical problems prior to the onset of your current symptoms: Give date on onset and description:

| Symptom | Description |
|---|---|
| Loss of consciousness | |

| | |
|---|---|
| Head injury | |
| Motor vehicle accidents | |
| Major falls, sports accidents or industrial accidents | |
| Seizures | |
| Stroke | |
| Brain infection or disorder | |
| Arteriosclerosis | |
| Diabetes | |
| Heart disease | |
| Cancer | |
| Back or neck injury | |
| Serious illnesses/disorder (immune, polio, lung, etc) | |
| Exposure to toxins (lead, solvents, chemicals) | |
| Major surgeries | |
| Psychiatric problems | |
| Other | |

Recent Tests
Indicate all tests that recently have been done and report any abnormal findings

| Test | Check in normal | Abnormal findings |
|---|---|---|
| Angiography | | |
| Blood work | | |
| CT scan | | |
| PET scan | | |
| SPECT | | |
| Skull x-ray | | |
| EEG | | |
| Neurological exam | | |
| Other | | |

Date of last vision exam:_____ Date of last hearing exam:_____

Are you currently under psychiatric or psychological care? If so, list the name(s) of the providers, both current and past, and the dates of service:

Have you had a prior psychological or neuropsychological exam? ___Yes ___No
If yes complete the following:

Name of psychologist:_____Date of exam:_____
Reason for evaluation:_____
Findings of the evaluation:_____

**SUBSTANCE USE HISTORY**
I started drinking at age:
____ less than 10 ____10 – 15 ____69 – 19 ____20 – 21 ____over 21

I drink alcohol:
____rarely or never ____ 1-2 days/week ____3-5days/week ____daily

I used to drink alcohol but stopped:_____ Date stopped:_____

Preferred type of drinks:_____

Usual number of drinks I have at one time:_____

Check all that apply:
____I can drink more than most people my age and size before I get drunk.
____I sometimes get into trouble (fights, legal difficulty, work problems, conflicts with family accidents, etc.) after drinking (specify):_____
____I sometimes black out after drinking.

Please check all the drugs you are now using or have used in the past:

| | Presently Using | Used in Past |
|---|---|---|
| Amphetamines (including diet pills) | | |
| Barbiturates (downers, etc.) | | |
| Cocaine or crack | | |
| Hallucinogenics (LSD< acid, STP, etc.) | | |
| Inhalants (glue, nitrous oxide, etc.) | | |
| Marijuana | | |
| Opiate narcotics (heroin, morphine, etc.) | | |
| PCP (angel dust) | | |
| Others: list them | | |

Do you consider yourself dependent on any of the above drugs? ___ Yes ___No
If yes, which one(s)? _____
Do you consider yourself dependent on any prescription drugs? ___ Yes ___No
If yes, which one(s)? _____

Check all that apply:
____I have gone through drug withdrawal
____I have used IV drugs
____I have been in drug treatment

Has use of drugs ever affected your work performance? _____
Has use of drugs or alcohol ever affected your driving ability?_____
Do you smoke tobacco? ____Yes ____No
If yes, amount per day?_____
Do you drink coffee or other caffeinated beverages? ____Yes ____No
If yes, amount per day?_____

**FAMILY HISTORY**

The following questions deal with your biological mother, father, brothers, and sisters:
Is your mother alive? ____Yes ____No
If deceased, what was the cause of her death?_____
At what age did she die?_____
Mother's highest level of education:_____
Mother's occupation:_____
Does your mother have a known or suspected learning disability? Yes No
If yes, please describe:_____
Is your father alive? ____Yes ____No
If deceased, what was the cause of his death?_____
At what age did he die?_____
Father's highest level of education:_____
Father's occupation:_____
Does your father have a known or suspected learning disability? Yes No
If yes, please describe:_____

Please check all problems that exist(ed) in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles). Note who it is (was) and describe the problem where indicated

| **Neurological disease** | Who? | Describe |
|---|---|---|
| Alzheimer's disease or senility | | |
| Huntington's disease | | |
| Multiple sclerosis | | |
| Parkinson's disease | | |
| Epilepsy or seizures | | |
| **Psychiatric illness** | Who? | Describe |
| Depression | | |
| Bipolar illness (Manic-Depression) | | |
| Schizophrenia | | |
| Other | | |
| **Other Disorders** | Who? | Describe |
| Mental retardation | | |
| Speech or language disorder | | |

| | | |
|---|---|---|
| Learning problems | | |
| Attention problems | | |
| Behavior problems | | |
| Other major disease or disorder | | |

**Symptom Survey:**
Please rate the severity of any current or recent (within the past 6 months) symptoms or problems by assigning either a 1,2,3,4 or 5 from the following scale:
1- very mild 2-somewhat mild 3-moderate 4-somewhat severe 5-severe
_____ anxiety, tension, nervousness
_____ coldness or numbness in fingers
_____tremor or shakiness
_____frequent or severe headaches
_____skin problems (i.e. rash, acne or dermatitis)
_____ frequent upset stomach/ indigestion/ nausea
_____headaches
_____depression or crying spells
_____chronic pain (specify_____)
_____dizziness or fainting spells
_____diarrhea or constipation/ urinary problems
_____memory problems/ inability to concentrate
_____excessive alcohol, drug or medication use
_____ excessive caffeine use (e.g. coffee, tea, chocolate, soda)
_____high blood pressure/ hypertension
_____muscle tension/ spasticity/ cramps
_____heart palpitations or pounding
_____frequent worrying/ preoccupation
_____stiffness, aching or burning sensation in joints
_____lack of energy/ frequent fatigue or sluggishness
_____lack of appetite
_____excessive appetite
_____shortness of breath/ rapid breathing
_____excessive fatigue
_____problems with falling asleep
_____ frequent wakening/ early wakening
_____excessive energy/ hyperactivity
_____sexual functioning problems
_____ irritability/ temper control problems
_____weakness on one side of the body
_____balance problems
_____fainting or blacking out
_____problems with fine motor control
_____loss of feeling or numbness
_____tingling or strange skin sensations
_____visual impairment: Do you wear glasses? _____ Yes ____No
_____problems seeing one side
_____sensitivity to bright lights

_____blurred vision
_____ see things or hear things that are not there
_____hearing loss: Do you have a hearing aid? _____Yes _____No
_____ Ringing in ears

Problem Solving:
_____Difficulty figuring out how to do new things
_____difficulty figuring out problems that most others can do
_____Difficulty planning ahead
_____Difficulty changing a plan or activity when necessary
_____Difficulty thinking as quickly as needed
_____Difficulty completing an activity in a reasonable time
_____Difficulty doing things in the right order (sequencing)

Language and Math skills:
_____Difficulty finding the right word
_____Slurred speech
_____Odd of unusual speech sounds
_____Difficulty expressing thoughts
_____Difficulty understanding what others say
_____Difficulty understanding what I read
_____Difficulty writing letters or words
_____Difficulty with math (e.g. balancing a checkbook, making change, etc)
_____Other problems:

Nonverbal Skill:
_____Difficulty telling right from left
_____Difficulty drawing or copying
_____Difficulty dressing
_____Difficulty doing things I should automatically be able to do (e.g. brushing teeth)
_____Problems finding way around familiar places
_____Problems recognizing objects or people
_____Parts of my body do not seem as if they belong to me
_____Decline in my musical abilities
_____ Not aware of time (e.g. day, season, year)
_____Slow reaction time

Attention and Concentration:
_____Highly distractible
_____Lose my train of thought easily
_____My mind goes blank a lot
_____Difficulty doing more than one thing at a time
_____Become easily confused and disoriented
_____Aura (strange feelings)
_____Don’t feel very alert or aware of things

_____Tasks require more effort or attention

Memory:
_____Forget where I leave things (e.g. keys, gloves, etc)
_____Forget names
_____Forget what I should be doing
_____Forget where I am or where I am going
_____Forget recent events
_____Forget appointments
_____Forget events that happened a long time ago
_____More reliant on others to remind me of things
_____More reliant on notes to remember things
_____Forget the order of things
_____Forget facts but I can remember how to do things
_____Forget faces of people I know

Mood/Behavior/ Personality
_____Sadness or depression
_____Anxiety or nervousness
_____Stress
_____Sleep problems (____falling asleep ____staying asleep)
_____Experience nightmares on a daily/weekly basis
_____Become angry more easily
_____Euphoria (feeling on top of the world)
_____Much more emotional
_____Feel as if I just don't care anymore
_____Easily frustrated
_____Doing things automatically 9without awareness)
_____Less inhibited (Do things I would not do before)
_____Difficulty being spontaneous
_____Change of energy (___decrease ____increase)
_____Change in appetite (___decrease ___increase)
_____Change in weight (___decrease ___increase)
_____Change in sexual interest (___decrease ___increase)
_____Lack of interest in pleasurable activities
_____Increase in irritability
_____Increase in aggression
_____Other changes in mood or personality or how you deal with people:
Please provide any additional information that you feel is relevant to this referral: