

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 her pregnancy with or delivery of you? 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: _____)
_____ Cohabiting (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? _____

Any relevant information regarding abortions or miscarriages? _____

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

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?

