BACKGROUND INFORMATION - FOR ADULTS

Instructions: *Patients or his/her family member should complete the following questionnaire. All information will be kept confidential. If you do not wish to respond to an item on the questionnaire, just write "no response" in the space provided.*

First Name | **Middle Name** | **Last Name**

Date of Birth | **Age** | **Grade**

Form Completed By | **Relationship** | **Today's Date**

SECTION 1 - DEMOGRAPHIC INFORMATION

Address (Number, Street, Apartment, City, State, Zip Code)

Phone Number(s) | **E-mail Address**

Wife's Name | **Husband's Name**

Marital Status: [ ] Married [ ] Divorced (for how long) _____
[ ] Unmarried [ ] Remarried (for how long) _____
[ ] Separated

Names of children or others residing in the home:

Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____

SECTION 2 – PREGNANCY/DELIVERY

Answer these to the best of your knowledge

Mother's general health during pregnancy:
[ ] Excellent [ ] Good [ ] Poor (please explain) _____

During pregnancy, indicate if your mother often used:
[ ] Cigarettes [ ] Alcohol [ ] Other drugs [ ] None of the above

Pregnancy was:
[ ] Without complications [ ] With complications (please explain) _____

Delivery was:
[ ] Without complications [ ] Induced [ ] C-Section [ ] Other (please explain) _____

Biirth weight was: _____ lbs _____ oz **Apgar scores:** _____

Your health at birth was:
[ ] Excellent [ ] Good [ ] Poor (please explain) _____

SECTION 3 – DEVELOPMENTAL HISTORY

Please place a mark [X] through the box if you had difficulty in any of these areas during the FIRST THREE YEARS of life.

[ ] Poor eye contact
[ ] Colicky/irritable
[ ] Sleep problems
[ ] Threw tantrums
[ ] Stubborn
[ ] Didn't get along well with peers/other children
[ ] Difficulty adjusting to schedules (e.g., eating, sleeping)
[ ] Resisted changes in schedule
[ ] Resisted affection from others
[ ] Slow cognitive development
[ ] Overly fearful
[ ] Difficult to comfort
[ ] Overactive
[ ] Accident prone
[ ] Separating from mother

Overall, as a toddler, I would describe my <u>temperament</u> as (check one):

[ ] Extremely difficult [ ] Difficult [ ] Average [ ] Very easy

Indicate the age at which you developed the following skills:

Crawling: _____
Walking: _____
First words: _____
Ability to complete simple chores independently: _____
Toilet training: _____
Riding a bike: _____
Getting dressed without help: _____
Throwing a ball: _____

SECTION 4 – MEDICAL HISTORY

Primary Care Physician_____ Phone # _____

Please place a mark through the box if you have had any of the following medical conditions.

[ ] Asthma _____
[ ] Allergies _____
[ ] Bedwetting _____
[ ] Diabetes _____
[ ] Seizure disorder _____
[ ] Surgeries – for what? _____
[ ] Head Trauma _____
[ ] Chronic ear infections _____
[ ] Hearing loss _____
[ ] Vision problems _____
[ ] Poor motor coordination _____
[ ] Sleep problems _____
[ ] Appetite problems (under/over eats) _____
[ ] Serious injuries (broken bones, stitches, etc.) _____

Overall, I would describe my current level of health as being: [ ] Excellent [ ] Good [ ] Poor

I am currently taking the following medications:

Name of medication _____ For what condition? _____
Name of medication _____ For what condition? _____
Name of medication _____ For what condition? _____
Name of medication _____ For what condition? _____
Name of medication _____ For what condition? _____

SECTION 5 – FAMILY HISTORY

Please check the box [X] if either of your biological parents have experienced any of the following conditions:

[ ] Attention-Deficit/Hyperactivity Disorder (ADHD/ADD)
[ ] Learning Disabilities/Academic Underachievement
[ ] Communcation disorders/disabilities
[ ] Depression
[ ] Anxiety Disorder(s)
[ ] Obsessive-Compulsive Disorder (OCD)
[ ] Autism/Asperger's Syndrome
[ ] Tourette's Syndrome
[ ] Substance Abuse
[ ] Criminal Misconduct

Please check the box if any of your biological siblings have experienced any of the following conditions:

[ ] Attention-Deficit/Hyperactivity Disorder (ADHD/ADD)
[ ] Learning Disabilities/Academic Underachievement
[ ] Communcation disorders/disabilities
[ ] Depression
[ ] Anxiety Disorder(s)
[ ] Obsessive-Compulsive Disorder (OCD)
[ ] Autism/Asperger's Syndrome
[ ] Tourette's Syndrome
[ ] Substance Abuse
[ ] Criminal Misconduct

SECTION 6 – EDUCATIONAL HISTORY

Please list previous schools you attended.

Name of school _____Major _____Degree _____
Name of school _____Major _____Degree _____
Name of school _____Major _____Degree _____
Name of school _____Major _____Degree _____

Please check the box [X] and provide brief details if the item is true about you. If you are unsure about an item, leave it blank.

[ ] I have been previously evaluated for school-related problems _____
[ ] I had to repeat a grade _____
[ ] I had difficulty learning academic material _____
[ ] I had difficulty following school rules _____
[ ] I had difficulty forming friendships at school _____
[ ] I resisted going to school and/or complained about disliking school _____
[ ] I received counseling at school _____
[ ] I was in special education (resource) _____
[ ] I had a 504 plan (IEP) _____
[ ] I had a medical condition that may have affected my ability to succeed at school – please describe _____
_____

Please describe any additional information about your school history that you feel might be helpful.

_____
_____
_____
_____

SECTION 7 – CURRENT BEHAVIORAL CONCERNS

Please place a mark [X] through the boxes that describe a current concern that you have about yourself.

Behavior

[ ] Overactive/always on the go
[ ] Impulsive; act without thinking about behavioral consequences
[ ] Distractible; shift focus from one activity to another
[ ] Difficulty complying to rules and expectations
[ ] Talk too much; interrupt others
[ ] Can‘t work quietly
[ ] Do not complete tasks or chores
[ ] Disorganized; frequently lose things
[ ] Forgetful; have trouble following directions
[ ] Impatient; difficult waiting for turn

Compliance to Rules and Social Norms

[ ] Refuse to comply with rules or social norms
[ ] Argue with adults
[ ] Throw tantrums or have outbursts
[ ] Physically aggressive toward others; get in fights
[ ] Destroy property
[ ] Dishonest; lie, cheat, steal
[ ] Bully/threaten others
[ ] Seem angry/vindictive

General Mood

[ ] Cry often or without apparent reason
[ ] Irritable/moody
[ ] Don't enjoy activities that used to be fun
[ ] Can’t sleep at night/sleep too much during the day
[ ] Express suicidal thoughts (“I don’t want to live anymore")
[ ] Loss of appetite
[ ] Excessive fatigue/loss of energy
[ ] Complain of having no friends
[ ] Complain about feeling unloved
[ ] Say to others that I'm depressed

Anxiety Level

[ ] Worry excessively (e.g., sickness, weather, safety, work)
[ ] Difficulty sleeping
[ ] Complain of headaches, stomachaches, nausea when not appearing sick
[ ] Loss of energy/easily fatigued
[ ] Difficulty separating from spouse/partner
[ ] Difficulty concentrating
[ ] Restless/easily agitated

Peer Relationships

[ ] Complain that “nobody likes me”
[ ] Bossy/have to have my own way
[ ] Don't follow rules when playing games
[ ] Don't show concern for the welfare of others
[ ] Have difficulty sharing and cooperating with others
[ ] Sore loser
[ ] Argue and fight with peers
[ ] Tease others
[ ] Bully others
[ ] Don't have a "best friend"

School Performance

[ ] Academic deficits; didn't learn as quickly as classmates
[ ] Behavior problem; disruptive/didn't follow rules
[ ] Failed to complete classwork and homework
[ ] Resisted going to school
[ ] Low test scores
[ ] Excessive absences/tardiness
[ ] Social problems; had few friends at school

SECTION 8 – ADDITIONAL INFORMATION

Please use the lines below to indicate your strengths and positive personality characteristics.

_____

_____

_____

_____

_____

_____

Please use the lines below to provide additional information about yourself that may be of importance for us to know.

_____

_____

_____

_____

_____

_____

Thank you for providing this information. Please bring the completed questionnaire with you to your appointment.