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ADULT BACKGROUND INFORMATION FORM

Patient's Name:_____ Age:_____ Today's Date:_____

Marital Status: ☐Single
☐Widowed Date of death_____
☐Married Date of marriage_____
☐Separated* Date of separation_____
☐Divorced* Date of divorce_____

*Please describe parenting time/custody arrangements:_____
_____

PRESENTING PROBLEMS

What concerns or problems, including symptoms, convinced you to seek help now?

_____
_____
_____
_____

These problems are: ☐mildly upsetting ☐moderately severe ☐very severe ☐totally incapacitating

How long has this been a problem? _____

Have you been treated for this problem before? ☐yes ☐no

If yes, who treated you? _____ When?_____

FAMILY INFORMATION

Spouse/Partner: _____ Age_____
Children (names & ages): _____
Mother:_____ Age_____ Deceased? ☐yes ☐no
Father:_____ Age_____ Deceased? ☐yes ☐no
Siblings (names & ages):_____

EDUCATION

Highest degree earned: _____ School: _____

JOB HISTORY

Current occupation: _____ Years on the job: _____
Previous occupation: _____ Years on the job: _____

ALCOHOL/DRUG USE

☐ Alcohol Frequency/amount:_____
☐ Tobacco Frequency/amount:_____
☐ Caffeine Frequency/amount:_____
☐ Other:_____ Frequency/amount:_____
Is there a history of alcoholism/substance dependency in immediate/extended family? ☐yes ☐no
If yes, who: _____

LEGAL HISTORY

Have you ever been arrested? ☐yes ☐no When?_____
If yes, for what reason _____
_____

SOCIAL HISTORY

With whom do you discuss difficult problems? ☐Family ☐Friends ☐Others:_____
What do you do for pleasure and relaxation? _____
_____
Do you exercise regularly? ☐yes ☐no
How would you describe your support system? ☐Adequate ☐Variable ☐Absent

MEDICAL HISTORY

Check all that apply

Type of Problem	During Childhood	Past as an adult	Currently
Allergies/asthma			
Cancer (type:_____)			
Diabetes			
Epilepsy or seizures			
Heart problems			
High blood pressure			
Injury resulting in loss of consciousness			
Irritable bowel			
Migraine headaches			
Problems with hearing			
Surgery (type:_____)			
Thyroid condition			

Any other serious medical problems (explain): _____
_____

Please list current medications, including over-the-counter:

Name of medication	Dose/frequency	Length of time on medication	Name of Prescribing Physician

Are you presently under a physician's care for physical problems? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

Have you ever experienced infertility? ☐ Yes ☐ No
If yes, describe infertility treatment and outcome: _____
_____

PSYCHIATRIC HISTORY OF SELF AND FAMILY

Family history (child, siblings, birthparents, uncles/aunts, cousins, grandparents) for any of the following
Check all that apply

	Self		Family Member/ Relationship to Client
	Past	Current	
Abuse (sexual, physical, neglect)			
ADHD/ADD			
Anxiety difficulties			
Autism			
Bipolar Disorder/Manic Depressive			
Depression/suicide (specify)			
Eating Disorders			
Explosive temper			
Learning difficulties			
Nervous breakdown/Schizophrenia			
Sleep disorders			
Other:			

Have you or any other family member ever been involved in therapy? ☐ Yes ☐ No

If yes, when: _____ Issues Addressed: _____
_____
_____
_____

Are you in treatment with another mental health provider at the current time? ☐ Yes ☐ No

If yes, provide name and telephone number: _____
_____

If necessary, would other family members be willing to attend therapy sessions? ☐ Yes ☐ No

What are your goals for therapy?_____
_____
_____