# Patient Background Form

**Today's date:**

**Your name:**

**Last, First Middle Initial**

**Date of birth:**       **Place of birth**

**What are your concern(s)?**

**What are your goals for therapy?**

**How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?**

## Medical History

Please explain any significant medical problems, symptoms, or illnesses:

**Current Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dosage | Purpose | Name of Prescribing Doctor |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Do you smoke or use tobacco?  If YES, how much per day?

Do you consume caffeine? If YES, how much per day?

Do you drink alcohol? If YES, how much per day/week/month/year?

Do you use any non-prescription drugs? (Please remember that this form is completely confidential).

If YES, what kinds and how often?

Previous Hospitalizations: (Approximate dates and reasons):

Have you ever talked with a psychiatrist, psychologist, or other mental health professional?

(Approximate dates and reasons):

## Family

How would you describe your past and present relationship with your mother?

How would you describe your past and present relationship with your father?

Are your parents still married? If they divorced, how old were you when they separated or divorced, and how did this impact you?

Are/were there any other primary care givers who you have/had a significant relationship with? If so, please describe how this person has impacted your life:

How many sisters do you have?       Names and ages?

How many brothers do you have?       Names and ages?

How would you describe your relationships with your siblings?

## Relationship Status

Currently in Relationship? Married/Life Partnered? If YES for either, how long?

How satisfied are you in that relationship?

Previously Married/Life Partnered? If YES, length of previous marriages/committed partnerships:

Do you have children? If YES, how many and what are their names and ages:

Describe any problems your children are having:

## Education

Attending school now? If YES, name of school:

Degree or diploma held:       Last school attended:

What is/was your experience of school/college: ­­­­­­­­­­­­­­­­­­­

## Legal Issues

Have you ever been convicted of a crime? If YES, please describe

Have you ever been incarcerated? If YES, please describe the location and length of incarceration(s):

# Additional Information

**Any additional information you would like to include:**

# Areas of Difficulty

Check all that apply. Which of these is the main issue?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Difficulty with:** | **Now** | **Past** | **Difficulty with:** | **Now** | **Past** | **Difficulty with:** | **Now** | **Past** |
| Anxiety |  |  | People in General |  |  | Nausea |  |  |
| Depression |  |  | Parents |  |  | Abdominal Distress |  |  |
| Mood Changes |  |  | Children |  |  | Fainting |  |  |
| Anger or Temper |  |  | Marriage/Partnership |  |  | Dizziness |  |  |
| Panic |  |  | Friends |  |  | Diarrhea |  |  |
| Fears |  |  | Co-workers |  |  | Shortness of Breath |  |  |
| Irritability |  |  | Employer |  |  | Chest Pain |  |  |
| Concentration |  |  | Finances |  |  | Lump in Throat |  |  |
| Headaches |  |  | Legal Problems |  |  | Sweating |  |  |
| Loss of Memory |  |  | Sexual Problems |  |  | Heart Palpitations |  |  |
| Excessive Worry |  |  | History of Child Abuse |  |  | Muscle Tension |  |  |
| Feeling Manic |  |  | History of Sexual Abuse |  |  | Pain in Joints |  |  |
| Trusting Others |  |  | Domestic Violence |  |  | Allergies |  |  |
| Communicating with Others |  |  | Thoughts of Hurting Someone Else |  |  | Often Make Careless Mistakes |  |  |
| Drugs |  |  | Hurting Self |  |  | Fidget Frequently |  |  |
| Alcohol |  |  | Thoughts of Suicide |  |  | Speak Without Thinking |  |  |
| Caffeine |  |  | Sleeping Too Much |  |  | Waiting Your Turn |  |  |
| Frequent Vomiting |  |  | Sleeping Too Little |  |  | Completing Tasks |  |  |
| Eating Problems |  |  | Getting to Sleep |  |  | Paying Attention |  |  |
| Severe Weight Gain |  |  | Waking Too Early |  |  | Easily Distracted by Noises |  |  |
| Severe Weight Loss |  |  | Nightmares |  |  | Hyperactivity |  |  |
| Blackouts |  |  | Head Injury |  |  | Chills / Hot Flashes |  |  |

## Family History

Check all that apply.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Drug / Alcohol Problems |  | Physical Abuse |  | Depression |
|  | Legal Trouble |  | Sexual Abuse |  | Anxiety |
|  | Domestic Violence |  | Hyperactivity |  | “Nervous Breakdown” |
|  | Suicide |  | Learning Disabilities |  | Psychiatric Hospitalization |