Joeanne Gutzwiller, Ph.D.
Child Psychology Services

2810 Mack Road, Fairfield, OH 45014-5130. (513) 874-4530

ADULT BACKGROUND AND HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____

Home Address _____ Home Phone _____

_____ Work Phone _____

Today's Date _____

Marital Status: _____ Single
_____ Married
_____ Living with a significant other
_____ Separated
_____ Divorced
_____ Widowed

Who lives in your home?

NAME	RELATIONSHIP TO YOU	DATE OF BIRTH

Pregnancy and Delivery

Please answer the following questions to the best of your ability.

Did your birth mother smoke during pregnancy? YES NO

Did your birth mother drink alcohol during pregnancy? YES NO

Did your birth mother use drugs during pregnancy? YES NO

Did your birth mother receive prenatal care during pregnancy? YES NO

Please describe any complications with your mother's pregnancy or delivery:

_____

_____

_____

Medical History

Name and address of your primary care physician: _____

_____

_____

As a child, were you diagnosed with any serious illnesses? YES NO

If yes, what illness

_____

_____

Do you currently have any of the following medical conditions?

_____ Asthma
_____ Allergies
_____ Cardiac disease
_____ Cancer or blood disease
_____ Cystic Fibrosis
_____ Diabetes
_____ Gastro-intestinal condition
_____ Headaches/Migraines
_____ High Blood Pressure
_____ Kidney disease
_____ Liver disease
_____ Obesity
_____ Neurological condition (Specify _____)
_____ Other (Specify _____)

If yes to any of the above conditions, please describe the treatment regimen:

_____

_____

_____

Do you have any food or drug allergies? YES NO DON'T KNOW

If yes, specify _____

Have you had a significant appetite change in the last month? YES NO

Comments: _____

Have you lost or gained more than 10 pounds in the past year? YES NO

Do you have difficulty sleeping? YES NO

If yes, please describe _____

Have you had a significant change in sleep patterns in the last month? YES NO

Comments: _____

Behavioral/Emotional Health History

Please indicate with a check mark any behavioral or emotional concerns during your childhood or adolescence:

_____ Bed wetting
_____ Inattention
_____ Hyperactivity
_____ Fears/Phobias
_____ Sad/Depressed mood
_____ Eating problems – strict dieting
_____ Eating problems – overeating
_____ Eating problems – bingeing and purging
_____ Eating problems – excessive exercise]
_____ Learning problems
_____ Difficulty getting along with peers
_____ Social skills problems
_____ Victim of teasing or bullying
_____ Bullying other children
_____ Arguing with adults
_____ Physically harming other people or animals
_____ Threatening physical harm to anyone
_____ Fire starting
_____ Running away from home
_____ Thinking about or attempting suicide
_____ Cutting or mutilating body
_____ Obsessive thoughts and/or actions
_____ Drug or alcohol use
_____ Motor tics
_____ Stuttering
_____ Victim of physical abuse
_____ Victim of sexual abuse
_____ Victim of emotional abuse
_____ Witnessed domestic violence
_____ Other significant trauma (Please specify: _____)

Other problems during your childhood/adolescence (Please specify):

_____

_____

_____

Current Concerns

Please indicate with a check mark any current problems you are experiencing:

_____ Inattention
_____ Hyperactivity
_____ Fears/Phobias
_____ Anxiety or nervousness
_____ Sad/Depressed mood
_____ Eating problems – strict dieting
_____ Eating problems – overeating
_____ Eating problems – bingeing and purging
_____ Eating problems – excessive exercise
_____ Employment problems
_____ Difficulty getting along with others
_____ Prefer being alone rather than with other people
_____ Arguing with others
_____ Physical confrontations with others
_____ Thinking about or attempting suicide
_____ Feelings of hopelessness
_____ Cutting or mutilating body
_____ Obsessive thoughts and/or actions
_____ Drug use
_____ Excessive alcohol consumption
_____ Motor tics
_____ Stuttering
_____ Victim of physical abuse
_____ Victim of sexual abuse
_____ Victim of emotional abuse
_____ Victim of domestic violence
_____ Grief or bereavement
_____ Difficulty coping with an illness
_____ Other significant trauma

(Please specify: _____)

Please use this space to elaborate on any current problems you are experiencing:

_____

_____

_____

_____

Have you had previous outpatient psychological treatment? YES NO

NAME OF THERAPIST	DATES OF TREATMENT	REASON FOR TREATMENT

Have you had previous inpatient psychological treatment? YES NO

NAME OF PROGRAM/FACILITY	DATES OF TREATMENT	REASON FOR TREATMENT

Have you ever had a psychological or neuropsychological evaluation? YES NO
If yes, what were the results?

Are you currently taking any medication (prescription, over-the-counter, vitamins, herbs, or supplements) for emotional, behavioral, academic, or medical reasons?

MEDICATION	DOSAGE	REASON

Significant Events

Please check any significant events you have experienced in the past 2 years:

_____ Loss of job/unemployment
_____ Death of an immediate family member
_____ Serious illness or injury to a family member or friend
_____ Financial problems
_____ Legal problems
_____ Divorce or separation
_____ Change in family structure (someone moved in/out of home, blending of families)

Education

What is the highest level of education you've completed?

_____ Less than high school diploma
_____ High school diploma
_____ GED
_____ Some college
_____ Associate's degree
_____ Bachelor's degree
_____ Master's degree
_____ Doctoral degree

Have you ever skipped a grade? YES NO

Have you ever repeated a grade? YES NO

Have you ever received any special academic services (e.g. special education, tutoring, gifted program)? YES NO

If yes to above question, please describe:

_____

_____

Family Health History

Have any family members (siblings, parents, aunts, uncles, cousins or grandparents) been diagnosed or treated for a mental health or substance abuse problem? YES NO DON'T KNOW

Please explain if yes to above question:

_____

_____

_____

Present Concerns

Why are you seeking assessment or therapy at the present time?

What are your strengths?

Other comments:

Thank you for completing this questionnaire.