BACKGROUND INFORMATION QUESTIONNAIRE

Name: _____

What are the main goals you hope to accomplish through treatment? _____

Circle or **bold** any of the following that apply to you now; <u>underline</u> any of the following that applied to you in the past:

Eating problems	Drinking too much	Taking drugs
Sleeping problems	Anxiety	Fears
Sexual problems	Poor concentration	Depression
Suicidal thoughts	Suicide attempts	Anger outbursts
Odd behavior	Unusual thoughts	Hearing voices
Unwanted habits	Crying	Hurting others
Isolation	Relationship problems	Family problems
Physical problems	Weight loss or gain	Pain
Nightmares	Being abused	Legal troubles
Work problems	School problems	Feeling unreal

Please elaborate on items you circled/underlined: _____

_____

_____

Have you had therapy or professional help before? Yes___ No ___
If yes, please explain (where, when, why): _____

Has any family member suffered from depression, alcoholism, or any nervous or emotional problems? Yes ____ No ____
If yes, please explain: _____

_____

Place of birth: _____ Religion: _____

Number of brothers _____ Brothers' ages _____

Number of sisters _____ Sisters' ages _____

Number of children _____Daughters' ages _____ Sons' ages _____

If living, age of your father or first parent _____

If not, what was the age at death? _____Cause of death? _____

First parent's occupation/former occupation: _____

If living, age of your mother or second parent _____

If not, what was the age at death? _____Cause of death? _____

Second parent's occupation/former occupation: _____

What is the last grade/degree you completed in school? _____

Current medical problems: _____

Medications: _____

Past medical problems (injuries/illnesses/surgeries): _____

Any concerns about gender or sexuality you wish to discuss? _____

_____