

BACKGROUND INFORMATION QUESTIONNAIRE

1. GENERAL INFORMATION

Name and Address

Name: _____ Nickname (if any): _____

Age: _____ Sex: M F Date of birth: ___/___/___ SS#: _____

Home address (include zip code): _____ Work address: _____

Phone: (____) ____ - _____ Phone (____) ____ - _____

Referred by: _____

Finances and Insurance

What are your present sources of financial support? (*Check all that apply*)

- Personal earnings Parents Savings Property Workers' Compensation
 Spouse's earnings Retirement Investments SSI Disability payments
 Friends Trust fund Inheritance
 Other _____

Benefits applied for: *Monthly benefit*

Social Security or SSI _____

Workers' Compensation _____

Disability insurance _____

Other insurance _____

Other benefits (specify) _____

Personal Information

Sexual identity: Heterosexual Bisexual Other _____
 Homosexual Transsexual

Marital status: Single Separated (since _____)
 Living together (since _____) Divorced (date _____)
 Married (date _____) Widowed (date _____)

For each prior marriage, please provide the following information:

	<i>Age at beginning</i>	<i>Age at ending</i>	<i>Type of termination (Divorce, Annulment, etc.)</i>	<i>Number of Male children</i>	<i>Number of female children</i>
1 st	_____	_____	_____	_____	_____
2 nd	_____	_____	_____	_____	_____
3 rd	_____	_____	_____	_____	_____

Current spouse or close partner:

Together since: _____ Age: _____ Religion: _____ Ethnic background: _____

Number of his/her prior marriages: _____ Number of children from prior marriages: _____

Years of education: _____ Type of employment: _____

Health problems: _____

Psychiatric problems: _____

Substance abuse problems: _____

Habits or behaviors that concern you: _____

Current living situation:

Type of residence: Apartment Condominium Home Other _____

Do you own or rent? Own Rent

How long have you lived at your current residence? _____

Do you live alone? Yes No

If not, who lives with you?

<i>Name(s)</i>	<i>Relationship</i>
_____	_____
_____	_____
_____	_____
_____	_____

Legal Information

Please respond Yes or No to each of the following questions:

Yes No

- Are you a citizen of the United States?
- Are you currently facing criminal proceedings of any kind?
- As an adolescent, were you ever detained by the police?
- Have you ever been arrested?
- Have you ever been convicted of a crime?
- Have you ever been known by or used another name?

If yes, please indicate name(s), including maiden name, and when used:

1. _____ (from age _____ to _____)
2. _____ (from age _____ to _____)
3. _____ (from age _____ to _____)

Is any legal action pending in relation to either a present condition or a previous health problem?

Yes No

If yes, please describe: _____

Indicate below the year and nature of each suit, both prior and ongoing.

	<i>Year filed</i>	<i>Nature of suit</i> <i>(Personal Injury, Medical Malpractice, etc.)</i>	<i>Ongoing or Resolved?</i>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Transportation Information

Do you presently operate a vehicle? Yes No

If no, when did you last drive? _____

Reason for no longer driving: _____

Do you have a current driver's license? Yes No

If no, when did you last have one? _____

	<i>No. of times</i>	<i>Year(s)</i>
Have you ever had a serious accident on a bicycle, scooter, or motorcycle?	_____	_____
Have you been involved in an automobile accident as a driver or passenger?	_____	_____
Have you ever been arrested for driving under the influence of alcohol?	_____	_____
Have you ever had your driver's license revoked or suspended?	_____	_____

Over the past 5 years, how many accidents have you been involved in as the driver (regardless of who was at fault)? _____

2. PERSONAL HISTORY

Background

Parents:

	<i>Father</i>	<i>Mother</i>
Ethnic background	_____	_____
Religion	_____	_____
Years of education	_____	_____
Academic degree(s), if any	_____	_____
Employment (before retirement)	_____	_____

Where were you born? _____

If born abroad, at what age did you enter the United States? _____

Prior residences:

Beginning with your birthplace, list all the cities or countries you have lived in.

	<i>From age</i>	<i>To age</i>	<i>City</i>	<i>State or Country</i>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Is English your native language? Yes No

If not, what is your native language? _____

At what age did you begin to speak English? _____

Other languages you speak, if any: 1. _____ 3. _____
2. _____ 4. _____

Were you raised in a particular religion? Yes No

If yes, which? _____

Current religion (if any): _____ How often do you attend services? _____

Please respond Yes or No to each of the following questions:

Yes No

- Were you adopted? If yes, at what age? _____
- Were you born a twin? If yes, which type? Fraternal Identical
- Did any of your siblings die late in pregnancy, at birth, in infancy, childhood, or adolescence?
- Did your parents divorce or separate before you were 18 years old?
If yes, what was your age at the time of their divorce/separation? _____
- Were you raised by a single parent? If yes, which? _____
- Were you raised by someone other than your parents? If yes, who? _____
- Did you feel abandoned or neglected as a child?
- Did either of your parents abuse alcohol or any other substance?
- Was either of your parents physically abusive to the other?
- Were you subjected to sexual abuse as a child or adolescent?
- Were you subjected to physical abuse as a child or adolescent?
- Have you ever struck, punched, or injured either a spouse or a romantic partner?
- Has any family member, friend, or colleague ever expressed concern regarding your use of alcohol or any other substance?
- Have you ever been in an abusive relationship, either as an adolescent or as an adult?
- Have you given a child/children up for adoption?
- Have you ever lost custody of a child/children?
- Have you ever been sexually assaulted? If yes, at what age? _____
- Have you ever been physically assaulted? If yes, at what age? _____
- Have you ever been tortured? If yes, at what age? _____
- Have you ever had a near-death experience?

Please respond Yes or No to each of the following questions:

Yes No

- Has a close friend, romantic partner, or spouse ever attempted or committed suicide?
- Have you sustained a major emotional, financial, or personal loss recently?
- Have you ever experienced a life-threatening natural disaster (e.g. earthquake, typhoon, hurricane)? If yes, please describe: _____
- Have you ever been robbed at gunpoint (or with any other weapon)?

Education

	<i>Name of school</i>	<i>City/State</i>	<i>Number of years completed</i>	<i>Date finished</i>	<i>Grade average (A,B,C,D,F)</i>	<i>Diploma Y/N</i>	<i>Degree (Specify)</i>
Elementary	_____	_____	_____	_____	_____		
Jr. High/Middle	_____	_____	_____	_____	_____		
High School	_____	_____	_____	_____	_____	_____	_____
University	_____	_____	_____	_____	_____	_____	_____
Graduate	_____	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____	_____

Total number of years of education completed: _____

In which subjects did you get the best grades? _____

In which subjects did you get the lowest grades? _____

SAT scores (if you know): Verbal _____ Math _____

Academic awards or honors (if any): _____

High School activities (if any): _____

College activities (if any): _____

Have you ever had your IQ tested? Yes No Don't know

Year: _____ Place: _____ Score (if known): _____

Please respond Yes or No to each of the following questions:

Yes No

- Did you skip any grades? If yes, which? _____
- Did you repeat or fail any grades? If yes, which? _____
- Did you have difficulty learning to speak, read, write, or spell? If yes, which? _____
- Were you placed in any special education classes? If yes, which? _____
- Were you ever told you were "hyperactive" or had "Attention Deficit Disorder"?
- Were you ever told you were "dyslexic"?
- Were you ever told you had a "learning disability"?
- Were you ever suspended or expelled from high school for academic reasons?
- Were you ever suspended or expelled from high school for disciplinary reasons?

Military Service

Did you serve in the military? Yes No

If yes, please provide the following information:

Dates of service: _____

Nature of discharge: _____

Highest rank: _____

Branch of service: _____

Assignment or MOS: _____

Did you see combat action? Yes No

Do you have a service-connected disability? Yes No

Were you ever court-martialed? Yes No

Employment Information

What are your career goals? _____

Are you currently employed? Yes No

If yes, please provide the following information:

Current job title: _____

Date current employment began: _____

City and state: _____

Number of hours worked per week: _____

Name of employer: _____

Name of immediate supervisor: _____

Approximate yearly salary or income: _____

Chief duties: _____

Are you satisfied with your present job? Yes No

Has your present physical condition resulted in any of the following:

Led to a change in your job title? Yes No

Led to a change in your job duties? Yes No

Forced you to limit your hours worked? Yes No

If yes, previous hours per week _____ Current hours per week _____

If you are not currently employed, please provide the following information

Date last worked: _____

Last employer: _____

City and state: _____

Position last held: _____

Last yearly salary or income: _____

Reason no longer working: _____

Prior employment (start with your earliest position):

	<i>Dates</i>	<i>Name of employer</i>	<i>Job title</i>	<i>Hours per week</i>	<i>Reason for leaving</i>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Have you ever been fired from a job? Yes No If yes, how many times? _____

Have you ever applied for either a pension or compensation for a disability? Yes No

If yes, in what years? 1. _____ 2. _____ 3. _____

Interests and Activities

<i>Current exercise (type)</i>	<i>Frequency (times per week)</i>	<i>Duration (length in minutes)</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your favorite type of music? _____

Do you own any pets? Yes No

<i>Organizations you belong to</i>	<i>Special talents or interests</i>
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Do you own a firearm of any type? Yes No If yes, which type(s)? _____

3. CURRENT PROBLEMS

What problem brings you here for evaluation? _____

Date of injury or concern (if known): _____

How did the problem begin (please check one)?

Suddenly Over days Over weeks Over months Over years

If your current problem(s) began following an accident, please describe the accident briefly.

What other major problems or concerns do you have, if any?

1. _____
2. _____
3. _____

Head and Neck (Check all that you currently experience. Where choices are provided, circle any that apply.)

- Loss of sense of smell
- Change in sense of smell or unexplained bad odors
- Loss of sense of taste or change in sense of taste
- Blurring, blindness, or double vision
- Visions or visual hallucinations
- Intolerance of light
- Facial numbness, pain, or drooping
- Hearing loss
- Hearing ringing or buzzing noises
- Hearing voices
- Hearing unexplainable or strange sounds
- Intolerance of noise
- Dizziness or problems with balance
- Difficulty chewing or swallowing
- Slurring of speech
- Hoarseness
- Change in quality of voice

Muscular System (Check all that you currently experience. Where choices are provided, circle any that apply.)

- Loss of strength
- Loss of coordination
- Slowness of movements
- Difficulty walking, gait instability, falling
- Chronic fatigue
- Muscle cramps
- Change in handwriting
- Shakes or tremors
- Involuntary movements: jerks, twitches, tic, head movements, hand movements, tongue or lip movements, blinking, other

Sensation (Check all that you currently experience)

- Numbness or loss of sensation
- Burning or tingling sensations
- Crawling sensations
- Pain

Emotion (Check all that you currently experience)

- | | | |
|---------------------------------------|--|--|
| <input type="radio"/> Anxiety | <input type="radio"/> Panic spells | <input type="radio"/> Change in personality |
| <input type="radio"/> Depression | <input type="radio"/> Emotional overreaction | <input type="radio"/> Change in sexual interest or drive |
| <input type="radio"/> Irritability | <input type="radio"/> Extreme mood swings | <input type="radio"/> Decreased capacity for pleasure or joy |
| <input type="radio"/> Apathy | <input type="radio"/> Change in sense of humor | <input type="radio"/> Feelings of hopelessness |
| <input type="radio"/> Frustration | <input type="radio"/> Fear of losing control | |
| <input type="radio"/> Anger | <input type="radio"/> Crying spells | |
| <input type="radio"/> Recurrent fears | | |

Behavior (Check all that you currently experience)

- Loss of energy
- Impaired sexual performance
- Aggression or violence toward other individuals, yourself, animals, objects
- Eating disturbance: increased appetite, decreased appetite, self-starvation (anorexia), binge eating or overeating (bulimia), self-induced vomiting or laxative use
- Sleep disturbance: difficulty falling asleep, insomnia, early waking, snoring, nightmares, sleepwalking, napping, daytime sleepiness
Other: _____
- Excessive shyness or hesitancy about career advancement, sexual behavior, social life
Other: _____
- Loss of control: sexual, verbal, rage attacks, emotional outbursts
Other: _____
- Repetitive or compulsive behavior: eating, cleaning, washing, rubbing, sex, gambling, nail biting
Other: _____
- Behavioral rituals: _____
- Involuntary behaviors: laughing, crying, vocalizations, perspiring, heart-racing, rapid breathing
Other: _____
- Current driving style: afraid to drive, inhibited, inattentive, reckless
Other: _____

Intellectual Abilities (Check all that you currently experience)

- | | |
|---|--|
| <input type="radio"/> Poor concentration | <input type="radio"/> Left-right confusion |
| <input type="radio"/> Slowness of thinking | <input type="radio"/> Difficulty with sense of direction |
| <input type="radio"/> Decreased clarity of thinking | <input type="radio"/> Episodes of getting lost |
| <input type="radio"/> Difficulty finding the right word | <input type="radio"/> Difficulty organizing or planning |
| <input type="radio"/> Use of wrong or inappropriate words | <input type="radio"/> Difficulty meeting deadlines |

Intellectual Abilities (Check all that you currently experience)

- Problems understanding what other people say
- Problems with reading
- Problems with spelling
- Problems with memory
- Special skills/talents (photographic memory, perfect pitch, etc.)
- Special mental abilities (telepathy, clairvoyance, etc.)

Thought Process (Check all that you currently experience. Where choices are provided, circle any that apply.)

- Racing thoughts
 - Unusual thoughts
 - Recurrent nightmares
 - Intrusive daytime thought, memories or flashbacks
 - Guilty feelings
 - Mental rituals
 - Preoccupation with finances, sex, cleanliness, etc.
 - Obsessions
 - Phobias
 - Feelings of persecution
 - Suicidal thoughts
 - Recurrent thoughts of death
 - Fears of hurting others
 - Violent fantasies
 - Fantasies of revenge or punishing others
 - Unusual feelings of familiarity or recognition for people, places, situations
- If yes, please describe: _____

4. MEDICAL HISTORY

General Information

- Height: _____ Weight: _____ Handedness: Left Right Ambidextrous
- Do you wear a hearing aid? Yes No
- Are you color-blind? Yes No
- Do you wear eyeglasses or contact lenses? Yes No If yes, which: _____
- Have you ever felt mistreated by a hospital or health care provider? Yes No
- Have you ever felt misunderstood or abandoned by a health care provider? Yes No

Birth Information

Please respond Yes or No to each of the following questions:

Yes No

- Did your mother have a major illness or a serious accident during the time she was pregnant with you?
- Did your mother drink or use drugs during the time she was pregnant with you?
- Were you born prematurely? If yes, how many weeks premature were you? _____
- Did you suffer any birth-related injury or problems such as Rh blood incompatibility, difficult delivery, "blue baby"? If yes, describe _____

Head Injuries and Other Injuries

List all motor vehicle injuries, work-related injuries, serious falls, fractures, etc. that you have experienced:

<i>Year</i>	<i>City</i>	<i>Cause of accident</i>	<i>Type of injury</i>	<i>Time unconscious (if any)</i>	<i>Length of hospitalization (if any)</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Surgery History

Have you ever had surgery? Yes No

If yes, please provide the following information:

	<i>Nature of surgery</i>	<i>Hospital</i>	<i>City</i>	<i>Date</i>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Medical Illnesses (Excluding Neurological Disorders)

Please list all major medical illnesses you have experienced and the year of diagnosis:

	<i>Illness</i>	<i>Year diagnosed</i>	<i>Current treating physician (if any)</i>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Neurological History

Have you ever consulted a neurologist? Yes No

Have you ever consulted a neurosurgeon? Yes No

	<i>Name of neurologist (N) or neurosurgeon (NS)</i>	<i>Indicate (N or NS)</i>	<i>Nature of problem</i>	<i>Dates of treatment (beginning to ending)</i>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Current headaches, if any (if you experience more than one kind of headache, please describe each kind separately):

	<i>1st kind</i>	<i>2nd kind</i>	<i>3rd kind</i>
Location (forehead, temple, behind left or right eye, etc.)	_____	_____	_____
Age at onset	_____	_____	_____
Frequency (average number per week/month/year)	_____	_____	_____
Intensity (mild, moderate, severe, incapacitating)	_____	_____	_____
Durations (indicate range from shortest or longest for each kind)	_____	_____	_____
Nausea and/or vomiting (Indicate N or V)	_____	_____	_____
Sensitivity to sound or light (indicate S or L)	_____	_____	_____
Associated problems with vision, speech, strength, etc. (if any)	_____	_____	_____
Treatment that works	_____	_____	_____

Other pain, if any:

	<i>1st kind</i>	<i>2nd kind</i>	<i>3rd kind</i>
Location	_____	_____	_____
Age at onset	_____	_____	_____
Description (dull, aching, stabbing, etc.)	_____	_____	_____
Intensity (mild, moderate, severe, incapacitating)	_____	_____	_____
Present during what % of your waking hours?	_____	_____	_____

Seizures, spells, or attacks, if any:

	<i>1st kind</i>	<i>2nd kind</i>	<i>3rd kind</i>
Behavior (fainting, vertigo, dizziness, shaking, etc.)	_____	_____	_____
Age at onset	_____	_____	_____
Frequency (average number per week/month/year)	_____	_____	_____
Warning signs or aura (if any)	_____	_____	_____
Specific triggers (if any)	_____	_____	_____

Please indicate if you have ever received any of the following procedures:

	<i>Date</i>	<i>City</i>	<i>Result (if known)</i>
CT head scan	_____	_____	_____
MRI head scan	_____	_____	_____
Other neuroimaging procedure(s) such as BEAM, SPECT, PET, etc. If so, which: _____	_____	_____	_____
EEG ("brain wave test")	_____	_____	_____
Evoked potential studies	_____	_____	_____
Lumbar puncture (spinal tap)	_____	_____	_____
Neuropsychological testing	_____	_____	_____

Psychiatric History

Have emotional or psychological concerns ever led you to consult any of the following?

- Psychiatrist Yes No Counselor Yes No
- Psychologist Yes No Clergy Yes No
- Therapist Yes No Other (specify): _____

If you responded yes to any of the above, please provide the following information:

	<i>Name and degree (PhD, MD, MFCC, LSCW, etc.)</i>	<i>City</i>	<i>Nature of problem</i>	<i>Dates of treatment (beginning to ending)</i>	<i>No. of visits per wk/mo/yr</i>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

Have you ever received psychological testing? Yes No

If yes, provide date: _____ Place: _____ By whom: _____

Have you ever attempted suicide? Yes No If yes, how many times? _____

Have you ever received electroconvulsive therapy (ECT)? Yes No How many times? _____

Have you ever been hospitalized for psychiatric reasons? Yes No How many times? _____

If yes, provide the following information for each hospitalization:

	<i>Name of hospital</i>	<i>City</i>	<i>Year</i>	<i>Duration of stay</i>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Review of Physical Condition

Check if you have ever had any of the following. Please circle specific examples (if provided) or feel free to describe (write in) your specific problem.

Heart and Lungs:

- Heart attack or chest pain
- Heart murmur or heart valve problem
- Infection of the heart or of a heart valve
- Irregular heart beat
- High blood pressure
- Low blood pressure
- Fainting spells
- Swollen ankles
- Shortness of breath when lying down flat
- Periods of rapid breathing with numbness of lips or fingers
- Lung disease (asthma, emphysema, tuberculosis, etc.), chronic cough, breathing problems of any kind
- Other heart or lung problem (describe): _____

Nervous System:

- Headaches
- Vision problems (describe): _____
- Hearing problems (describe): _____
- Balance problems, dizziness, vertigo (describe): _____
- Major infections (rheumatic fever, meningitis, encephalitis)
- Loss of consciousness without head injury, fainting, drop attacks
- Periods of time for which you have no memory
- Strokes or any episodes of neurologic impairment
- Seizures, epileptic fits, or "spells"

Abdomen:

- Stomach, intestinal or bowel problems, vomiting, ulcers, colitis, blood in stool, tarry stools, diverticulitis, hemorrhoids, persistent diarrhea or constipation, flatulence, excessive belching, incontinence of stool
- Liver disease, jaundice, hepatitis, cirrhosis, other liver disease
- Gallbladder problems
- Other: _____

Urinary:

- Kidney, urinary, prostate, or bladder problems (increased frequency of urination, need to urinate that interferes with sleep, pain on urination, bed wetting, incontinence of urine, nephritis, uremia, kidney stones, blood in urine)
- Venereal disease (syphilis, gonorrhea, herpes, genital warts, etc.)

Blood:

- Anemia, bleeding problems, or easy bruising
- Blood transfusions
- Sharing of hypodermic needles
- Unprotected sexual intercourse with a person known to be, or later determined to be, HIV-positive
- HIV antibody test? If yes, provide date: _____ Results: _____

Bones:

- Fractures or dislocations
- Neck problems
- Back problems
- Brittle bones (osteoporosis)
- Joint problems: pain, swelling, gout, arthritis
- Torn ligaments or tendons
- Dental or orthodontic problems that persist (dentures, TMJ-syndrome, etc.)

Skin:

- Scars
- Change in skin texture
- Tattoos
- Change in pattern or amount of sweating
- Skin problems (psoriasis, warts, melanoma, cysts, acne, etc.)
- Cosmetic surgery, including rhinoplasty, facelift, eyelid surgery, breast augmentation or reduction, liposuction, etc.

Glands (Endocrine):

- Diabetes (age first diagnosed): _____
- Thyroid problems (goiter, use of thyroid extract, thyroid surgery, radiation treatment)
- Other endocrine problems (pituitary, adrenal, pancreas, parathyroid)
- Intolerance of heat or cold

Miscellaneous:

- Allergies Cancer Noncancerous tumors or growths Mononucleosis
- Weight loss that was unintentional Diagnosis of chronic fatigue syndrome
- Diagnosis of "Multiple Chemical Sensitivities" or "environmental allergies"
- Exposure to known toxins (describe): _____

Female History

Please respond Yes or No to each of the following questions:

Yes No

- Do you experience irregular periods?
- Do you have problems with sexual intercourse (i.e., pain or absence of orgasm)?
- Do you take birth control pills?
- Have you ever been diagnosed with premenstrual syndrome?
- Have you experienced difficulty conceiving?
- Have you ever had a tubal ligation or any other type of tubal surgery?
- Have you reached menopause? If yes, at what age? _____
- Have you had a hysterectomy? If yes, at what age? _____
- Do you take hormones? If yes, at what age did you first take them? _____

Male History

Please respond Yes or No to each of the following questions:

Yes No

- Do you have difficulty achieving or maintaining an erection?
- Do you have ejaculatory difficulties?
- Have you had a vasectomy?
- Have you ever experienced rectal bleeding, injury, or infection associated with sexual behavior?
- Have you had prostate surgery?

Substance Use

Please indicate any non-prescribed substances you have used, even if only a few times.

	<i>Age first used</i>	<i>Age last used</i>	<i>Current amount per day or week</i>
<input type="radio"/> Alcohol	_____	_____	_____
If you consume alcohol now, what types? _____			
Maximum amount ever consumed on a regular basis (for weeks or months): _____			
Have you ever experienced any of the following?			
<input type="radio"/> Blackouts or memory problems	<input type="radio"/> Alcohol-related accident(s)	<input type="radio"/> Delirium tremens	
<input type="radio"/> Shakes	<input type="radio"/> Alcohol-related stomach problems	<input type="radio"/> Alcohol-related divorce	
<input type="radio"/> Withdrawal seizures	<input type="radio"/> Alcohol-related liver problems	<input type="radio"/> Alcohol-related job loss	
<input type="radio"/> Caffeine	_____	_____	_____
<input type="radio"/> Cigarettes	_____	_____	_____
<input type="radio"/> Pipe, cigar, chewing tobacco	_____	_____	_____
If so, which? _____			
<input type="radio"/> Anabolic steroids	_____	_____	_____
<input type="radio"/> Tranquilizers	_____	_____	_____
<input type="radio"/> Barbiturates	_____	_____	_____
<input type="radio"/> Demerol	_____	_____	_____
<input type="radio"/> Glue sniffing	_____	_____	_____
<input type="radio"/> Gasoline sniffing	_____	_____	_____
<input type="radio"/> Other inhalant sniffing	_____	_____	_____
<input type="radio"/> Marijuana	_____	_____	_____
<input type="radio"/> Nitrates ("Poppers")	_____	_____	_____
<input type="radio"/> MDMA ("Ecstasy")	_____	_____	_____
<input type="radio"/> Mescaline (Peyote)	_____	_____	_____
<input type="radio"/> Psilocybin (Mushrooms)	_____	_____	_____
<input type="radio"/> LSD ("Acid")	_____	_____	_____
<input type="radio"/> PCP ("Angel Dust")	_____	_____	_____
<input type="radio"/> Amphetamines ("Speed")	_____	_____	_____
<input type="radio"/> Cocaine ("Crack" of Free Base)	_____	_____	_____
<input type="radio"/> Heroin	_____	_____	_____
<input type="radio"/> Morphine or Opium	_____	_____	_____
<input type="radio"/> I.V. drug use (specify): _____	_____	_____	_____
<input type="radio"/> Other (specify): _____	_____	_____	_____

Treatment for Addictive Behaviors

List any substance abuse, 12-step, or other addiction treatment programs in which you have participated (AA, Alanon, Narcotics Anon., Cocaine Anon., Marijuana Anon., Gamblers Anon., Weight Watchers, etc.):

	<i>Name of program</i>	<i>Dates of treatment (beginning to ending)</i>	<i>Location</i>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Current Medications

List all prescribed and over-the-counter medicines that you take regularly. Include vitamins, supplements, and immune-enhancers:

	<i>Medication</i>	<i>Strength</i>	<i>Number of tablets per day</i>	<i>Month and year started</i>	<i>Physician prescribing</i>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

List all medications or other products that you take occasionally:

	<i>Medication</i>	<i>Strength</i>	<i>Number of tablets per day</i>	<i>Month and year started</i>	<i>Physician prescribing</i>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Previous Medications

List those medications that either have not been helpful or that you were forced to stop taking:

	<i>Medication</i>	<i>Maximum dosage per day</i>	<i>Taken for how long</i>	<i>Date last taken</i>	<i>Reason stopped</i>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

Allergies and Adverse Reactions

List any medications or substances to which you have had a significant allergic or adverse reaction:

	<i>Medication or substance</i>	<i>Type of allergic or adverse reaction</i>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Other Therapies (Past and Current)

List all treatment programs in which you have participated:

	<i>Location</i>	<i>Dates of treatment (beginning to ending)</i>	<i>No. of visits per wk/mo/yr</i>
Head injury rehab. (inpatient)	_____	_____	_____
Head injury rehab. (outpatient)	_____	_____	_____
Physical therapy	_____	_____	_____
Chiropractic treatment	_____	_____	_____
Biofeedback	_____	_____	_____
Massage	_____	_____	_____
Hypnosis	_____	_____	_____
Other: _____	_____	_____	_____

Do you practice meditation? Yes No

If yes, indicate the type of meditation: _____

Year you began: _____ How many times do you meditate per week? _____

Do you have any problems with sleep onset? Yes No

Do you have any problems with sleep maintenance? Yes No

Avg. number of hours of sleep per night: _____

Avg. number of times waking up during the night: _____

5. FAMILY HISTORY

	<i>Name</i>	<i>Age (if living)</i>	<i>Medical, surgical, neurological, psychiatric, or substance abuse problems</i>	<i>Age at death (if deceased)</i>	<i>Cause of death</i>	<i>Year of death</i>
Mother:	_____	_____	_____	_____	_____	_____
Father:	_____	_____	_____	_____	_____	_____
Adoptive mother:	_____	_____	_____	_____	_____	_____
Adoptive father:	_____	_____	_____	_____	_____	_____
Brothers and sisters:	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

Name	Age (if living)	Medical, surgical, neurological, psychiatric, or substance abuse problems	Age at death (if deceased)	Cause of death	Year of death
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Brothers and sisters by adoption , half-siblings, or step siblings:

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Children:

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is there a family history of any of the following neurological problems? *(Please respond Yes or No to each)*

Yes	No		Specify which relative(s)	Approximate age at onset
<input type="radio"/>	<input type="radio"/>	Headache	_____	_____
<input type="radio"/>	<input type="radio"/>	Aneurysm or vascular malformation	_____	_____
<input type="radio"/>	<input type="radio"/>	Movement disorder	_____	_____
<input type="radio"/>	<input type="radio"/>	Shakes or tremors	_____	_____
<input type="radio"/>	<input type="radio"/>	Convulsions, seizures, or epilepsy	_____	_____
<input type="radio"/>	<input type="radio"/>	Sleep disorder	_____	_____
<input type="radio"/>	<input type="radio"/>	Intellectual deterioration before age 60	_____	_____
<input type="radio"/>	<input type="radio"/>	Dyslexia or other learning disorder	_____	_____
<input type="radio"/>	<input type="radio"/>	Hyperactivity or Attention Deficit Disorder	_____	_____
<input type="radio"/>	<input type="radio"/>	Mental retardation	_____	_____
<input type="radio"/>	<input type="radio"/>	Huntington's disease	_____	_____
<input type="radio"/>	<input type="radio"/>	AIDS	_____	_____
<input type="radio"/>	<input type="radio"/>	Syphilis	_____	_____
<input type="radio"/>	<input type="radio"/>	Other neurological disorder	_____	_____

Is there a family history of any of the following psychiatric problems? *(Please respond Yes or No to each)*

Yes	No		Specify which relative(s)	Approximate age at onset
<input type="radio"/>	<input type="radio"/>	Depression	_____	_____
<input type="radio"/>	<input type="radio"/>	Mania	_____	_____
<input type="radio"/>	<input type="radio"/>	Suicide or suicide attempts	_____	_____
<input type="radio"/>	<input type="radio"/>	Anxiety or panic disorder	_____	_____
<input type="radio"/>	<input type="radio"/>	Obsessive compulsive disorder	_____	_____
<input type="radio"/>	<input type="radio"/>	Eating disorder	_____	_____
<input type="radio"/>	<input type="radio"/>	Paranoia	_____	_____
<input type="radio"/>	<input type="radio"/>	Schizophrenia	_____	_____
<input type="radio"/>	<input type="radio"/>	Autism	_____	_____
<input type="radio"/>	<input type="radio"/>	Substance abuse	_____	_____
<input type="radio"/>	<input type="radio"/>	Hospitalization for mental illness	_____	_____
<input type="radio"/>	<input type="radio"/>	Outpatient treatment for mental illness	_____	_____
<input type="radio"/>	<input type="radio"/>	Untreated mental illness	_____	_____

Is there any other known inherited illness in your family? Yes No

If yes, please describe: _____

Name of your primary doctor: _____

Specialty (if any): _____

Address: _____

Phone: (____) _____ - _____

Who completed this questionnaire? _____

If other than patient, indicate relationship to patient (parent, spouse, attorney, etc.): _____

How much time was spent completing this questionnaire? _____

Signature of patient: _____ Date: _____