BACKGROUND HISTORY QUESTIONNAIRE

Please fill out the following questionnaire as best as you can. If you have any questions, or if there is any information you do not know, leave it blank. Please remember to bring this questionnaire with you to your scheduled appointment. **Try to arrive FIFTEEN (15) minutes before your appointment time.**

Date form completed: _____________

Who is filling out this form: ☐ Patient ☐ Other; name: _______________________________

If other, do you live with the patient? ☐ No ☐ Yes Relation to patient: ___________
Contact information (daytime phone number, e-mail, address, etc.): _________________

Patient's Name: _______________________________________ **Date of Birth**: _____________

Address: ____
Street **City** **State** **Zip**

Home Phone (______)________________________ Cell Phone (______)_______________________

E-mail: ____

Gender: ☐ Male ☐ Female ☐ Transgender **Handedness**: ☐ Right ☐ Left ☐ Both

Ethnicity/Race: ☐ Hisp/Latino ☐ Amer Ind ☐ African-Amer ☐ Asian ☐ Pacific Isl ☐ White

Do you live at home? ☐ Yes ☐ No [specify where you live:_______________________ **]**

Do you have a(n): Advance directive? ☐ No ☐ Yes **Living will?** ☐ No ☐ Yes
Healthcare proxy? ☐ No ☐ Yes [name:____]
Durable Power of Attorney? ☐ No ☐ Yes [name: ________________________________]

Do you have a religious affiliation? ☐ Yes ☐ No [specify:_____________________________ **]**

REFERRAL INFORMATION

Brief summary of your main complaints (describe the problems you've been experiencing, including when & how they began, and if they have gotten better or worse since they started; continue on back if necessary)**:** ____

____

____

Have you had any blood work or head/brain scans (i.e., CT or MRI)? ☐ No ☐ Yes
If yes, what tests were done, when, and where? ____

Is the reason for referral due to an injury, accident, or illness? ☐ No ☐ Yes
If yes, date of injury/accident/illness: ___________________

Were you injured on the job (worker's comp)? ☐ No ☐ Yes

Is this evaluation part of a lawsuit or criminal charge? ☐ No ☐ Yes Attorney: _____________

CURRENT FUNCTIONING

How do you typically spend most of your time each day (what activities do you usually engage in)**?**
____
____

Do you exercise regularly? ☐ No ☐ Yes [specify: ____________________________________]
How often: ☐ less than 3days per week ☐ 3-5 days per week ☐ 6 or 7 days per week
On average, for how long each day: ☐ 30 minutes or less ☐ 30-60 minutes ☐ over 60 minutes

Other hobbies/interests: ____

SLEEP
Avg. time **go to bed**: _____ Avg. time **wake in morning**: ______ # times wake up at night: ______

Do you: feel rested when you wake up? ☐ No ☐ Yes **Take naps** during the day? ☐ No ☐ Yes

Problems with: ☐ falling asleep ☐ staying asleep ☐ waking too early and can't fall back asleep
☐ bad dreams ☐ sleepwalking ☐ sleep apnea [CPAP: ☐ No ☐ Yes]

Do you take medications to help you sleep: ☐ No ☐ Yes [specify: ______________________]

APPETITE / WEIGHT
My appetite is: ☐ very good ☐ good ☐ fair ☐ poor

During the past *3 to 6 months*, my ***appetite*** has ☐ stayed the same ☐ increased ☐ decreased
Reasons for appetite change: ____

During the past *3 to 6 months*, my ***weight*** has: ☐ stayed the same ☐ increased ☐ decreased
Reasons for weight change: ____

VISION AND HEARING
Do you wear glasses or contacts? ☐ No ☐ Yes [specify: ☐ for distance ☐ for reading]
Most recent eye exam: ___________________ [month/year]
Problems with: ☐ blurred vision ☐ double vision ☐ light sensitivity ☐ colorblind [__________]

Do you wear hearing aids? ☐ No ☐ Yes [specify: ☐ both ears ☐ right only ☐ left only]
Most recent hearing exam: ____________________ [month/year]
Problems with: ☐ ringing in ears ☐ sound sensitivity

ACTIVITIES OF DAILY LIVING

Check any of the following daily activities that you currently NEED ASSISTANCE for:

☐ Getting dressed ☐ Bathing/showering ☐ Using restroom ☐ Taking medications
☐ Laundry ☐ Use telephone ☐ Prepare food ☐ Cooking
☐ Cleaning ☐ Shopping ☐ Driving ☐ Paying/managing bills
☐ Other [specify: ____]

COGNITIVE PROBLEMS

Check any of the following that you are *currently having problems* with:

☐ Forgetting events, appointments, dates
☐ Forgetting to take medications
☐ Forgetting recent events/conversations
☐ Forgetting things that happened a long time ago
☐ Forgetting where you are/how you got there
☐ Getting lost in familiar places
☐ Asking same thing over and over again
☐ Losing/misplacing objects repeatedly
☐ Forgetting people's names
☐ Difficulty with routine chores/tasks
☐ Trouble concentrating/focusing
☐ Easily distracted
☐ Trouble expressing thoughts/finding words
☐ Calling objects the wrong name
☐ Other: [specify: ______________]
☐ Other: [specify: ______________]

MOOD

Check any of the following that you are *currently* experiencing:

☐ General feeling unwell ☐ Depression ("the blues") ☐ Crying
☐ Irritability ☐ Temper outbursts ☐ Physical aggression
☐ Wandering ☐ Recklessness ☐ High energy/little need for sleep
☐ Excessive worrying ☐ Tenseness/anxiety ☐ Impatience
☐ Poor judgement ☐ Sexual disinhibition ☐ Paranoia
☐ Indifference ☐ Loss of interest in activities ☐ Withdrawal from social activity
☐ Delusions or Hallucinations (seeing/hearing things not really there) [specify: __________________]
☐ Thoughts of hurting self ☐ Thoughts of hurting others ☐ Other: [specify: ______________]

BACKGROUND INFORMATION

Birth place: __________________________________ If not USA, year moved to USA? _________

Where did you live most of your childhood: ____

First language: _____________________ If not English, years of formal English study? _______

Marital Status: ☐ Single-never married ☐ Single-with partner ☐ Married ☐ Separated

☐ Divorced, not remarried ☐ Divorced, remarried ☐ Widowed ☐ Other

I have been married a total of: ____ times

CHILDREN:
Do you have children? ☐ No ☐ Yes **# sons** ___ [ages ______] **# daughters** ___ [ages ______]

Do any of your children live with you now? ☐ No ☐ Yes [which ones: ______________________]

Do any of your children have health problems? ☐ No ☐ Yes [specify: ______________________]

PARENTS:
Mother: ☐ Living [health is ☐ excellent ☐ good/normal ☐ fair ☐ poor ☐ unknown]
☐ Deceased [year: _________; age: _____; cause of death: ______________________]
☐ Unknown
Mother's level of education: ___________ Occupation: ____________________________

Father: ☐ Living [health is ☐ excellent ☐ good/normal ☐ fair ☐ poor ☐ unknown]
☐ Deceased [year: _________; age: _____; cause of death: ______________________]
☐ Unknown
Father's level of education: ___________ Occupation: ____________________________

SIBLINGS:
Biological brothers: _____ # Half-brothers: _____ # Step-brothers: _____
Biological sisters: _____ # Half-sisters: _____ # Step-sisters: _____

Do any of your siblings have health problems? ☐ No ☐ Yes [specify: ______________________]

Are you the: ☐ Oldest ☐ Middle ☐ Youngest ☐ Other: ____________________

BIRTH, EARLY DEVELOPMENT

Please answer the below questions to the best of your knowledge:
Any problems during your mother's pregnancy with you? ☐ No ☐ Yes [specify:_______________]

Any problems during birth? ☐ No ☐ Yes [specify:__________________]

Were you slow to learn how to walk, talk, or use the toilet? ☐ No ☐ Yes [specify:______________]

Any major and/or unusual illnesses during childhood? ☐ No ☐ Yes [specify:__________________]

History of physical/mental/sexual abuse during childhood/adolescence? ☐ No ☐ Yes ☐ Possibly
[explain:____]

Problems/stresses in home growing up (e.g., divorce, death, serious illness)? ☐ No ☐ Yes [_______]

EDUCATION

Check the highest level of education completed:

☐ Didn't finish school, highest level reached: ________ ☐ High school graduate ☐ GED
☐ Some college [how many yrs ______, ☐ full time ☐ part time
☐ 2-yr College (AS) / Vocational Training [where: ___________; field of study: ________________]
☐ 4-yr college (BS/BA) [where: ____________________; degree/major: ______________________]
☐ MA/MS [where: _________________________; degree/major: ___________________________]
☐ PhD/MD/EdD/JD/etc. [where: ______________________; degree/major: _____________________]

Average grades in *high school*: _________ **Average grades in *college*:** _________

Best/Easiest/Favorite Subject: ____

Worst/Hardest/Least Favorite Subject: ____

Have you ever been *held back/repeat a grade*? ☐ No ☐ Yes [grade:___; reason: ______________]

Ever diagnosed with *learning difficulty*? ☐ No ☐ Reading ☐ Writing ☐ Spelling ☐ Math

Ever been told you have *Attention Deficit Disorder* [ADD or ADHD] ☐ No ☐ Yes Age: _____
Who tested you/made diagnosis? ☐ Teacher ☐ Psych ☐ Other [specify: ________________]

MILITARY/EMPLOYMENT HISTORY

MILITARY

Have you ever been in the military? ☐ No ☐ Yes Start: _______ End: ________
Branch: __________________ MOS: ____________________ Where? _______________________
Highest Rank: ____ Discharge Rank: ____ Discharge Type: ☐ Honorable ☐ General ☐ Other
Do you have a service connected disability? ☐ No ☐ Yes [specify below]
% ____ for ____________________ % ____ for ______________________

EMPLOYMENT

Are you currently: ☐ Employed ☐ Employed-on leave ☐ Unemployed, but looking ☐ Student
☐ Homemaker ☐ Retired [year: ____] ☐ Disability ☐ SSI/SSD [______]

CURRENT or MOST RECENT job: Title/description: ___________________________________
Employer: ____ Avg. hours/week: ________
I started working at this job: ______ [month/year] I last worked here on: _______ [date]

PRIOR JOBS (starting with most recent first; use back if you have additional prior jobs)
Title/description: __________________________ Employer: _________________________________
Start Date: ___________ End Date: ___________ Avg. hours/week: ________________
Reasons for leaving: ____

Patient's Name: ________________________________

Title/description: ___________________________ Employer: ___________________________________
Start Date: ____________ End Date: ____________ Avg. hours/week: _________________
Reasons for leaving: ____

DRIVING HISTORY

Do you have a valid driver's license? ☐ No ☐ Yes

Ever lost license / had it suspended? ☐ No ☐ Yes [when:______; why: _____________________]

If **currently driving**, have any of the following occurred? ☐ Getting lost ☐ Tickets ☐ Accidents
# of motor (car/truck/motorcycle) accidents have you been involved in the last **5 years**? ____

If **not driving**, when did you stop? ___________ Why did you stop? ☐ Never drove ☐ Accident
☐ License revoked ☐ Medical / Police order ☐ Other [specify: _________________]

LEGAL HISTORY

Have you ever been arrested? ☐ No ☐ Yes [specify date(s) and reason(s): ____________________
____]

Ever been engaged in a lawsuit claim (including any current/ongoing lawsuits)? ☐ No ☐ Yes
☐ Personal Injury ☐ Harassment ☐ Unlawful Termination ☐ Other: ____________
Please provide details including when, what the lawsuit was about, who was involved, and what the outcome was: ____

HEAD INJURIES

Have you ever had a head injury ☐ No ☐ Yes
(an injury in which (a) you either hit your head on something, (b) something hit your head, or (c) you experience such a severe whiplash that you were dazed, confused, or unconscious)

Head Injury # 1 (most recent)
Date: _____ Lose consciousness? ☐ No ☐ Yes For how long? ___________
Cause: ☐ Fall ☐ Motor vehicle (car/motorcycle) ☐ Fight ☐ Hit by object ☐ Other __________
Lose consciousness? ☐ No ☐ Yes For how long? ___________
Describe the injury/accident (include any hospitalizations, treatment): _____________________
____

Head Injury # 2
Date: ______ Lose consciousness? ☐ No ☐ Yes For how long? ___________
Cause: ☐ Fall ☐ Motor vehicle (car/motorcycle) ☐ Fight ☐ Hit by object ☐ Other _________
Describe the injury/accident (include any hospitalizations, treatment): ______________________

____

Any more head injuries? ☐ No ☐ Yes [If yes, please provide details on back of page]

FALL HISTORY

History of falls? ☐No ☐Yes

Difficulty walking? ☐No ☐Yes **Do you use a:** ☐cane ☐walker ☐wheelchair]

Fall # 1 (most recent) Date: _______ Where? ____________ What were you doing? ______________

Were you injured? ☐ No ☐ Yes [describe, include any treatment): ______________________

____

Fall # 2 Date: _______ Where? _______________ What were you doing? ________________

Were you injured? ☐ No ☐ Yes [describe, include any treatment): ______________________

____

Any others falls that result in injury? ☐ No ☐ Yes [If yes, please provide details on back of page]

MEDICAL HISTORY

MEDICATIONS

Please list all medications, including over-the-counter, herbal supplements, and vitamins. Include dose, how many times a day you take it, and reason for taking. Please continue on the back of this page or attach additional sheets.

1. ____

2. ____

3. ____

4. ____

5. ____

ALLERGIES

Medication Allergies? ☐ No ☐ Yes [specify: ______________________________]

Food/ environmental/other allergies? ☐ No ☐ Yes [specify: ___________________________]

SURGICAL HISTORY

Please list any surgical procedures, starting with the most recent. Include date, type of surgery, and where/who performed (use back if need more space)

1. ____

Patient's Name: _______________________________

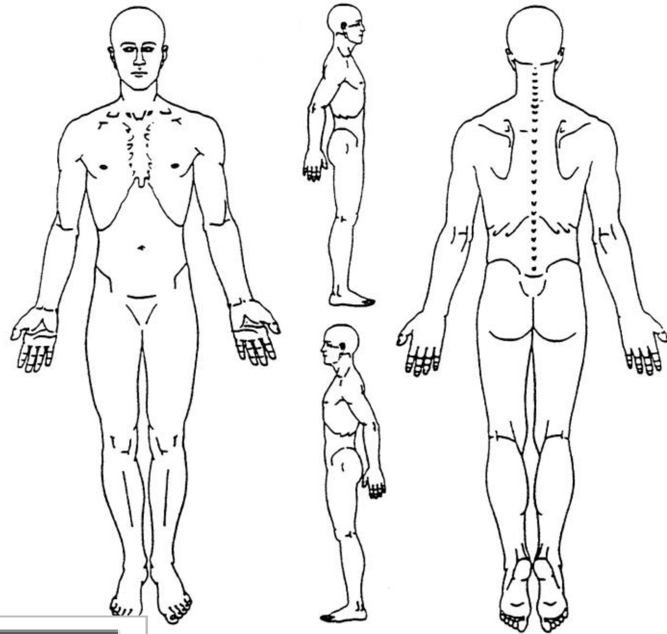
2. ____

3. ____

PAIN

Do you have any pain today? ☐ No ☐ Yes

[specify where by placing "X" on the drawing]



What helps reduce your pain? __________________

____

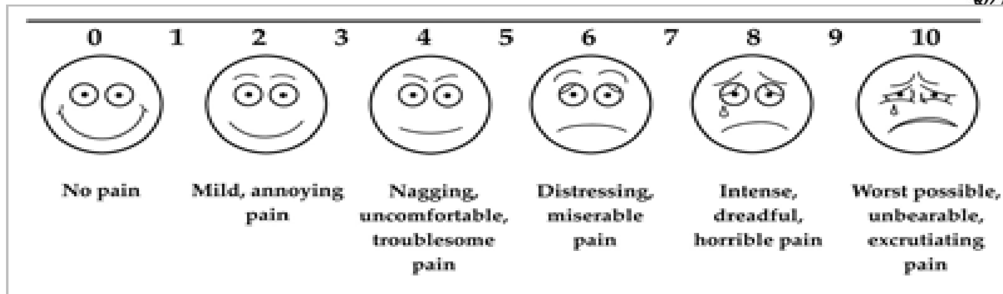
What makes your pain worse? __________________

____

Using the scale below:

What is your **current** pain level (0-10)? _______

What is your **average** pain level (0-10)? _______



MEDICAL HISTORY (check NO or YES for all that apply to YOU or a family member)

ILLNESS/CONDITION	Me?	Family Member?	
Alzheimer's disease	☐No ☐Yes	☐No ☐Yes	***(circle)*** child brother sister father mother grandfather grandmother
Arrhythmia / Atrial fibrillation	☐No ☐Yes	☐No ☐Yes	***(circle)*** child brother sister father mother grandfather grandmother
Bladder disease [chronic infection; cancer]	☐No ☐Yes	☐No ☐Yes	***(circle)*** child brother sister father mother grandfather grandmother
Bowel disease [Crohn's; cancer; obstruction]	☐No ☐Yes	☐No ☐Yes	***(circle)*** child brother sister father mother grandfather grandmother
Breast Cancer	☐No ☐Yes	☐No ☐Yes	***(circle)*** child brother sister father mother grandfather grandmother
Circulatory Problems [hands, legs, feet]	☐No ☐Yes	☐No ☐Yes	***(circle)*** child brother sister father mother grandfather grandmother
Congestive heart failure	☐No ☐Yes	☐No ☐Yes	***(circle)*** child brother sister father mother grandfather grandmother
Diabetes [type 1 or type 2]	☐No ☐Yes	☐No ☐Yes	***(circle)*** child brother sister father mother grandfather grandmother

Patient's Name: _________________________________

ILLNESS/CONDITION	Me?	Family Member?
Eating disorder	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Epilepsy / Seizures	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Fibromyalgia	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Headache / migraine	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Heart attack	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
High blood pressure	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
High cholesterol	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Kidney disease [kidney stones, kidney failure]	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Liver disease [cirrhosis, hepatitis, jaundice]	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Lupus	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Lyme Disease	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Multiple Sclerosis [MS]	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Osteoarthritis [OA]	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Osteoporosis	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Ovarian / Prostate Cancer	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Parkinson's disease	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Respiratory disease [such as: COPD, asthma, chronic bronchitis]	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Rheumatoid Arthritis [RA]	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Sexual disorder / dysfunction	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Stomach disease [ulcers; gastritis; cancer]	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Stroke / brain hemorrhage	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Thyroid disease	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother
Tuberculosis	☐No ☐Yes	☐No ☐Yes (*circle*) child brother sister father mother grandfather grandmother

Patient's Name: ___________________________________

MENTAL HEALTH HISTORY

Have you **ever been treated** for a mental health problem? ☐ No ☐ Yes

For what: ☐ Depression ☐ Anxiety ☐ PTSD ☐ Schizophrenia
☐ Bipolar/Manic ☐ School ☐ Legal ☐ Marital/Relationship
☐ Parent/Sibling ☐ Work ☐ Other [specify: ______________________]

When: ___________________ Treatment Provider: __________________________________

Type of treatment: ☐ Individual (one-to-one) ☐ Couples ☐ Family ☐ Group

How often (e.g., weekly, monthly, etc.): ____________

Medication(s)? ☐ No ☐ Yes [specify: ____]

Are you **currently in treatment** for mental health problem? ☐ No ☐ Yes

Name of provider(s): ____

Type of treatment: ☐ Individual (one-to-one) ☐ Couples ☐ Family ☐ Group

How often (e.g., weekly, monthly, etc.): ____________

Medication(s)? ☐ No ☐ Yes [specify: ____]

SUBSTANCE USE HISTORY

CAFFEINE

Do you drink coffee/tea/caffeinated beverages? ☐ No, never ☐ Yes

Type: ☐ coffee ☐ tea ☐ soda ☐ other : _______________ How much per day: ________

ALCOHOL

Do you drink alcohol: ☐ No, never ☐ Former, quit date:________ ☐ Yes

If yes, how much do you usually drink? (include drink of choice and quantity): _____________

Frequency: ☐ Very rarely or never ☐ 1-2 times per month ☐ About one a week
☐ 2-5 times per week ☐ About every day ☐ Wine with meals
☐ Several drinks per day

Has alcohol use ever caused a problem in: ☐ Marriage ☐ Family ☐ Work ☐ School
☐ Military ☐ Financial ☐ Legal ☐ Medical conditions

Provide details (when, where, how, frequency, etc.): __________________________________

Have you ever been in a treatment program for alcohol use? ☐ No ☐ Yes

When/where: ____

TOBACCO

Do you use tobacco/nicotine products: ☐ No, never ☐ Former, quit date:______ ☐ Yes

If yes, type: ☐ cigarettes ☐ cigars ☐ vape / e-cigs ☐ chew

How much per day? _________________ Are you trying to cut down or quit? ☐ No ☐ Yes

Patient’s Name: _______________________________

OTHER

Please choose the description that **currently** fits best:

☐ Not a current regular user of any recreational drugs, but at a younger age I experimented with drugs
☐ I occasionally use marijuana, but not other drugs such as cocaine, heroin, methamphetamines, etc.
☐ I now use marijuana 1- 4 times a month
☐ I now use marijuana more than 4 times a month
☐ I use one or more drugs (other than marijuana) at least once a month. Which ones? _____________

Has substance use ever caused a problem in: ☐ Marriage ☐ Family ☐ Work ☐ School
☐ Military ☐ Financial ☐ Legal ☐ Medical conditions

Provide details (when, where, how, frequency, etc.): ________________________________

Have you ever been in a treatment program for substance use? ☐ No ☐ Yes

When/where: ____

ANYTHING ELSE?

Is there anything else that you feel is important about your present condition? _______________

____

Are there any questions you have prior to the appointment beginning? ____________________

____

THANK YOU!!

We appreciate your time and cooperation, and look forward to meeting you.

Patient's Name: ______________________________