ADULT HISTORY & BACKGROUND QUESTIONNAIRE

George Mason University Center for Psychological Services
01/12/11 Version

Please answer all of the questions below, even if some may not apply directly to you. In order to help us learn more about you, please bring your provider photocopies of your recent school or job records, standardized test score results, and any educational, medical, or psychological reports.

DEMOGRAPHIC INFORMATION

YOUR NAME: _____ DATE TODAY: /_____/_____/_____/

GENDER (circle): Male Female YOUR AGE: _____years BIRTH DATE: /_____/_____/_____/
Month/ Day/ Year

RACE (circle any that apply)**:**
American Indian/Alaskan Native Asian Black/African American Hawaiian/Pacific Islander White Other

ETHNICITY (circle which apply): Hispanic/Latino Not Hispanic/Latino

HOME ADDRESS: _____ DAYTIME PHONE_____

_____ CELL/OTHER PHONE_____

PREVIOUS DIAGNOSES OR EDUCATIONAL PLACEMENT/CLASSIFICATION: _____

RECENT PSYCHOLOGICAL/EDUCATIONAL TESTS TAKEN: _____

Person filling out this form (circle): Self Spouse/Partner Friend Mother Father Sibling Child Other _____

REASON FOR REFERRAL

Who referred you to GMU CPS? _____ Phone Number:_____

Briefly describe the reason(s) you have come to GMU CPS. _____

_____

_____

How long has this reason been noticeable to you? _____ How old were you when symptoms were first noticed? _____

What seems to help it? _____

_____

What seems to make it worse? _____

_____

How often do you notice the problem? _____

_____

What areas of your life are most affected and how (e.g., relationships, school, job)? _____

_____

_____

Is the problem affected by stress? Yes No If *Yes*, please list major sources of stress. _____

_____

Have any other family members shown similar characteristics? Yes No Whom? _____

Have you received a previous evaluation or intervention for similar reasons? Yes No

If yes, when and with whom?_____

_____

Are you on any medication at this time? Yes No If yes, please write name(s):_____

_____

Is any legal action currently underway? Yes No If *Yes*, please explain. _____

_____

_____

MENTAL HEALTH HISTORY

Have you been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit Hyperactivity Disorder (ADHD), Learning Disorder (LD), or Anxiety and Mood Disorders? Yes No If *Yes*, please specify:

_____

Are you currently in treatment with any mental health or behavioral health provider?

If yes, with whom _____ Phone Number:_____

For what condition(s)? _____

Note: We will likely need your permission to communicate with this professional.

Please list any previous mental health services you have received and the nature of the service (e.g. individual psychotherapy once per week for anxiety; medication management for mood disorder, etc.):

Age	Diagnosis	Type of Service	Duration of Service

JOB HISTORY

List your most recent job/employment, along with your title/position. _____

When and how long were you employed at this job? _____

List some of your duties at this job. _____

Did you receive any special recognition at this job? _____

Were there any special problems you experienced at this job? _____

List previous jobs (including length of employment and reason for leaving), beginning with most recent. _____

_____

_____

_____

Have you ever been fired from a job? Yes No If *Yes*, explain _____

Have you ever served in the military? ? Yes No Rank at discharge? _____ Type of discharge _____

EDUCATIONAL HISTORY

List the most recent education you have received (e.g., high school, vocational school, college). _____

What is the highest degree you have earned, and from what educational institution? _____

When did you attend this school? _____ For how long? _____

What type of grades did you receive in school? _____

What were your best and worst subjects? _____

Did you have any special difficulties or receive any special services in school? Yes No If *Yes*, explain. _____

_____

Did you ever change schools for reasons other than normal academic progression? Yes No If *Yes*, when and for what reason?

_____

Did you ever skip or repeat a grade in school? Yes No If *Yes*, explain _____

HOME AND SOCIAL INFORMATION

Describe your marital status (circle one). Single Living together Married Divorced Widowed Other_____

With whom do you live? List first names and relationships (e.g., spouse, child, parent, sibling, friend) below:

Name (Relationship): _____ Age:_____ Education:_____ Occupation: _____

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Name (Relationship): _____ Age:_____ Education:_____ Occupation: _____

Describe social and emotional support currently available to you? _____

Are any family members a source of support to you? Yes No Are any friends a source of support to you? Yes No

About how many friends would you describe as *close*? ___None ___One ___Two or three ___Four or more

How often do you see or talk with your friends? _____

List any activities or organizations that you belong to. _____

Do you attend any religious services regularly? Yes No If *Yes*, please describe _____

_____

How often do you use alcohol, and what do you typically drink? _____

List any recreation drugs you use and how often you use them. _____

Have you used more alcohol or drugs than you intended this year? Yes No

Have you ever felt the need to cut down on the amount you drink or use drugs? Yes No

MEDICAL HISTORY

Physician's name: _____Phone Number: _____

Date of most recent medical exam _____

Do you currently see any other doctors/professionals? If so, please list:

Name	Phone	For what?
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have ever undergone an operation or hospitalization, please list the problem below (usually an illness), your age, and the medical procedures that were implemented during the hospitalization.

Problem (or illness)	Age	Medical Procedures during the Hospitalization
_____	____	_____
_____	____	_____
_____	____	_____

If you have ever been treated with prescription medication other than for colds and minor infections, please list them below:

Medication	Age	Reason Prescribed
_____	____	_____
_____	____	_____
_____	____	_____

Do you have any *current* medical conditions? Yes No If *Yes*, please list. _____

Do you have any *chronic or recurrent* medical conditions? Yes No If *Yes*, please list. _____

_____

PREVIOUS ILLNESSES:

Place a check next to any illness or condition that you have had. Wrote the approximate date (or your age at the time) next to illnesses within the

last two years.

Illness or Condition	Illness or Condition	Illness or Condition
___ Anemia	___ Epilepsy or seizures	___ Loss of consciousness
___ Arthritis (juvenile)	___ Fainting	___ Malnutrition
___ Bleeding problems	___ Fatigue (if chronic and severe)	___ Measles
___ Bone or joint disease	___ Hay fever	___ German measles
___ Broken bones	___ Head injury	___ Meningitis
___ Cancer	___ Headaches (frequent or severe)	___ Mumps
___ Chicken pox	___ Heart disease	___ Paralysis
___ Diabetes	___ Hepatitis	___ Rheumatic fever
___ Diphtheria	___ High blood pressure (hypertension)	___ Scarlet fever
___ Eczema or hives	___ High fever (greater than 104 degrees)	___ Tuberculosis
___ Encephalitis	___ Jaundice	___ Whooping cough

VISION: Date of most recent vision exam _____

Do you have any vision problems ? Yes No If *Yes*, is your vision corrected with (circle one): Eyeglasses Contact lenses Surgery

HEARING: Date of most recent hearing exam _____

Do you have any hearing problems ? Yes No If *Yes*, has your hearing been treated? _____

FAMILY MEDICAL HISTORY

Have any other family members shown similar problems or challenges? Yes No If *Yes*, who? _____

_____

Place a check next to any illness or condition that any member of the family has had. When you check an item, please note the FAMILY member's relationship to you.

Condition	Relationship to you		
____ ADHD or Hyperactivity	_____	____ High Blood Pressure	_____
____ Anxiety or Worry Problem	_____	____ Huntington's Chorea	_____
____ Depression	_____	____ Kidney Disease	_____
____ Learning problems	_____	____ Mental Retardation	_____
____ Manic-Depressive Disorder	_____	____ Migraine Headaches	_____
____ Reading Problem	_____	____ Muscular Dystrophy	_____
____ Speech or Language Problem	_____	____ Multiple Sclerosis	_____
____ Sexual/physical abuse	_____	____ Nervous Breakdown or Problems	_____
		____ Parkinson's Disease	_____
____ Alcoholism	_____	____ Physical Handicap or Disability	_____
____ Alzheimer's Disease	_____	____ Seizures or Epilepsy	_____
____ Birth Defect	_____	____ Sickle Cell Anemia	_____
____ Cancer	_____	____ Stroke	_____
____ Cerebral Palsy	_____	____ Suicide attempt	_____
____ Cystic Fibrosis	_____	____ Tay-Sachs Disease	_____
____ Diabetes	_____	____ Tourette's Syndrome or Tic Disorder	_____
____ Drug Addiction or Dependency	_____	____ Tuberculosis	_____
____ Heart Disease or Heart Attack	_____	____ Other_____	_____
____ Hemophilia	_____		

Is there any other information that you think may help us in understanding and working with you? _____

_____

_____

_____