**Integrated Health and Behavior, PLLC**
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# BACKGROUND INFORMATION

**If completing this form for another person, please answer as the person would answer.**

Name: _____ Nickname: _____
What pharmacy do you use?_____
If you were referred to us, who referred you?_____
What is their phone number?_____

Who lives with you?_____
Status: Single___ Married___ Widowed___ Divorced___ Separated___ Other_____
If you were married previously, please give dates:_____

Please tell us briefly why you want treatment:_____
_____
When did you start having problems?_____
What has helped make it better?_____
What has made it worse?_____
Is this the worst it has been? _____

Have you been in therapy before? Yes □ No □
Whom did you see?_____
_____
When did you see them?_____
Was it helpful? Yes □ No □
Please explain:_____

Do you have any previous psychiatric hospitalizations? Yes □ No □
If so, when and where?_____
Have you ever attempted suicide? Yes □ No □
If so, when and how?_____
If you have a previous diagnosis, what is it? _____

Please list (Psychiatric) medicines you have tried in the past.

| Medications: | Dosage: | Side Effects: | Allergies: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently on any psychiatric medications? Yes □ No □
If so, please list names and doses:

| Medication: | Dosage: | Side Effects: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Are you taking any other medications not already listed? Yes □ No □
If so, please list names and doses:

| Medication: | Dosage: | Side Effects: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Do you have any allergies to medication? Yes □ No □
If yes, please list: _____

How is your appetite?_____
Do you have an eating disorder or a history of an eating disorder (i.e. throwing up, purging, restricting)? Yes □ No □

How do you sleep?_____
Do you snore or use a CPAP? Yes □ No □
Do you have nightmares? Yes □ No □
How many in the last 2 weeks? (Circle one) 1-3 4-9 10-14

Has anyone ever abused/neglected you in any way? Yes □ No □
If yes, please explain:_____

Do you make and keep friends easily? Yes □ No □

How is your energy level? High □ Low □ Normal

Do you have any problems paying attention or sitting still? Yes □ No □
Do you have problems with staying organized? Yes □ No □
How is your concentration (i.e. can you concentrate on reading, etc.)? _____
_____

Are you currently having any problems at work or school? Yes □ No □
If yes, please explain:_____
What was the last grade you completed in school? _____
How did school go for you?_____
Did you have any learning disabilities?_____
Did you have an IEP or a 504 plan?_____

Are you sad or moody? Yes □ No □
Are you fearful or anxious? Yes □ No □

Do you find yourself having to repeat the same actions (for example: checking, counting or washing)? Yes □ No □
If yes, please explain:_____

Do you have any phobias? Yes □ No □
If yes, what of?_____
Do you have panic attacks? Yes □ No □
If yes, please explain:_____

Have you ever been depressed? Yes □ No □
If yes, please explain:_____
Do you have any problems with your weight? Yes □ No □
Do you cry frequently? Yes □ No □

Have you ever stayed awake for 2 or more days? Yes □ No □
Have you ever been manic? Yes □ No □
Do you have times of intense or excessive spending? Yes □ No □

Do you have tantrums, or are you angry or aggressive? Yes □ No □
Have you ever had violent behavior? Yes □ No □

Do you currently smoke, vape, or use tobacco products? Yes □ No □
Do you drink alcohol currently or have you in the past? Yes □ No □
How much?_____
How often? (Circle one) Daily Weekly Monthly Other: _____
Have you ever used non-prescribed medications? Yes □ No □
Which medications?_____
How much? How often?_____
Have you undergone treatment for substance abuse? Yes □ No □
Do you use marijuana (even medicinally)? Yes □ No □
Are you concerned about the amount of alcohol you drink? Yes □ No □
Have you had a DUI? Yes □ No □
Have you had a blackout? Yes □ No □
Do you have any legal charges related to substance abuse? Yes □ No □
Are firearms in your home? Yes □ No □

Are you presently having any legal issues (for example: suspension, expulsion, arrest, probation, bankruptcy, custody battle)? Yes □ No □
If yes, which issues?_____
Are you involved in any litigation? Yes □ No □
If yes, please explain:_____

Have you ever had a perceptual disturbance (i.e. seeing or hearing something when nothing was there? Yes □ No □
Please explain:_____

Have you purposely cut or hurt yourself in the past? Yes □ No □
If so, how and when?_____

If female, is there any chance you could be pregnant? Yes □ No □

**Do you have problems in any of these areas? If so, please circle:**

| | |
|---|---|
| Constitutional | Sweats, weight changes, appetite, often get sick, always cold or hot |
| Respiratory | Wheezing, breathing, shortness of breath |
| Cardiac | Dizziness, fatigue, chest pain, limitations on exertion, heart palpitations, difficulty breathing while laying flat |
| GI | Trouble eating or drinking or swallowing, vomiting, constipation, diarrhea, abdominal pain, blood in stool, heartburn |
| GU | Soiling during day or night, excessive urination, strong odor to urine |
| Musculoskeletal | Muscle pain, weakness, rigidity, ticks, tremors, excessive clumsiness |
| Skin | Rashes, sores, itchy or sensitive skin |
| ENT | Trouble hearing, ear tubes, abnormal hearing exams, teeth/gum problems |
| Taste | Trouble with taste, trouble swallowing foods |
| Vision | Contacts or glasses, problems with seeing clearly, glaucoma |
| Speech | Stuttering, unclear speech, gone to speech therapy |
| Neurological | Weakness, staring spells, had a neurological evaluation |
| Gynecological | Breast cancer, ovarian cancer, STD, history of kidney or bladder stone |
| Endocrine | Problems with pancreas, or with pituitary thyroid or adrenal glands |
| Immune | Problems with easy bruising |

Do you currently have any active medical problems? Yes □ No □
If yes, what are they?_____
Have you had any cardiac problems? Yes □ No □
Do you have chronic pain? Yes □ No □
Have you had a head injury or concussion? Yes □ No □
If so, when?_____
Have you seen any other medical specialist within the last 5 years? Yes □ No □
If so, for what purpose did you see them?_____
Please list any previous surgeries and year received:_____
_____
_____
Have you ever been hospitalized overnight for a reason other than the ones given above? Yes □ No □
If so, for what cause?_____

Were you adopted? Yes □ No □
Do you have any relatives who have suffered with an emotional disorder or mental illness? Yes □ No □
If yes, please explain:_____
Do you have any relatives who have died by suicide? Yes □ No □
If yes, who and when?_____
Do you have any relatives who have been hospitalized psychiatrically? Yes □ No □
Have any of these relatives received treatment? Yes □ No □
If so, was it helpful? Please explain:_____
_____
Do you have any relatives with sudden death from cardiac arrhythmia? Yes □ No □

Do you have friends that use drugs or are a bad influence? Yes □ No □
What are your friends like? _____
Are you experiencing any relationship problems? Yes □ No □

Occupation:_____ Employer:_____
How long at this occupation?_____ How long at present job?_____
How is work going for you?_____
Military service? Yes □ No □
Are you experiencing any financial problems? Yes □ No □

What things do you find stressful? _____

Who are the people who help you?_____
_____

What are your talents?_____

What are your strengths?_____

What are your goals for treatment?_____
_____

Will you make yourself available for appointments between 9 am and 3 pm? Yes□ No□

Please Rank how often you have been bothered by any of the following problems in **the last 2 weeks**.

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead or hurting yourself in some way | 0 | 1 | 2 | 3 |

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| | | | |

**The following questions are for children and adolescents only:**

How much did your child weigh at birth (approximately)?_____

Were there any complications with birth (i.e. forceps, breech, labor induced, NICU stay, C-section)?_____

Did your child crawl and walk on time?_____

When did your child start talking?_____

At what age was your child toilet trained?_____

How does your child play with other children?_____

Did or does your child have any sensitivities to fabrics, noise, foods?_____

_____

Did or does your child have any habits, mannerisms, or ticks – i.e. moving hands a certain way, flapping hands, walking on toes, etc?_____

_____

Did or does your child have any unusual interests?_____

_____

Does your child have any unusual storage habits (i.e. hiding or hoarding food, etc.)?___

_____

How is your child's behavior/temperament (ex: energetic, easy to soothe, etc)?_____

_____

Do you consider your child soft hearted or hard hearted?_____

Why?_____

**By my signature below, I attest that the above answers are true and correct to the best of my knowledge:**

Signed:

_____

Name Printed:

_____

Date: _____