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BACKGROUND INFORMATION FORM

IDENTIFYING INFORMATION			
Name	**Date of Birth**	**Age**	**Occupation or School & Grade**

Reason for Consultation

Current Medications					
Medication:	**Dose:**	**Taken since:**	**Medication:**	**Dose:**	**Taken since:**

FAMILY MEMBERS & OTHER RESIDENTS OF HOUSEHOLD			
Name	**Relationship**	**Age**	**Occupation or School & Grade**

Please describe briefly the quality of your relationship with each of the above individuals, for example: degree of closeness, cooperation, level and frequency of conflict, and the like.	

Family & job stressors that may be impacting you, with a description of impact (e.g., arguing; marital separation or divorce; extended family problems; job stress; illnesses/hospitalizations/ deaths; elder care; changes of residence

EDUCATION & EMPLOYMENT HISTORY

Please describe briefly your academic & job history, noting any strengths, challenges, or concerns.

Year	Age	Setting	Comments

PRIOR EVALUATIONS AND TREATMENT

Please describe previous testing, evaluations, consultations, or therapy. If available, copies of written reports are usually helpful in understanding your current concerns.

Year	Age	Evaluator	Comments

EXTENDED FAMILY PSYCHIATRIC HISTORY **Please list any history of psychiatric treatment among blood relatives, including emotional problems, alcohol/drug abuse, suicide, attention or learning problems, and related medications**.	
Relationship	**Comments**

MEDICAL HISTORY **Comments about health problems and medical concerns, including: genetic conditions, allergies, surgeries, injuries, illnesses, concussions, or high fevers.**		
Year	**Age**	**Health Concern:**

CURRENT HEALTH HABITS	
Current Height:	**Current Weight:**
Diet	**Comments on habits & preferences (e.g.: regular meals OR snacks; well balanced diet OR missing food groups; preference for sweets, carbohydrates); current or past eating disorders**
Sleep	**Comments on current and past sleep patterns (e.g.: difficulty falling asleep, staying asleep, wake early and unable to fall back asleep; past periods of disturbed sleep; wake tired or moody)**
Substance Use	**Use of caffeine (coffee, tea, colas); tobacco; alcohol; marijuana; other off-the-shelf, legal, illegal, designer drugs; first use; current frequency of use; comments**
Fears	**Comments on pattern of worries, fears, or anxieties; any concerns**
Sadness	**Comments on mood changes; intensity; consistency; onset & recovery; any concerns**
Anger	**Comments on irritability; quickness & intensity of anger; onset & recovery; any concerns**

Feel free to include any documentation that can help me to better understand the full nature of your current concerns and also how past events relate to these concerns. Thank you for taking the time to complete this form, which will help me with assessment and with planning and recommendations.

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Signature Date