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Adult Background History:

Name	
Who completed this form?	
Birthdate	
Age	
Date of Appointment	
Gender	
Ethnicity	

Social History:

Where were you born? _____

Please list all of the different cities in which you have lived since birth.

Location	Ages or Dates

About your parents:

Name of Parent	Job	Mental Health difficulties?	Relationship with you?	Health?
		Yes No	Poor Fair Good	Poor Fair Good Deceased
		Yes No	Poor Fair Good	Poor Fair Good Deceased

Are your parents still married to each other or together? Yes No

If not, how old were you when they divorced/separated? _____

If divorced /separated, did your parents marry other people? Yes No

Please complete this table for any step-parents:

Name of Parent	Job	Mental Health difficulties?	Relationship?	Health?
		Yes No	Poor Fair Good	Poor Fair Good Deceased
		Yes No	Poor Fair Good	Poor Fair Good Deceased

If your parents were divorced, which parent did you live with? Mom Dad Both Other:_____

Custody Schedule: Full Time:_____50/50 Split:_____ Weekends:_____

No Contact:_____ Other:_____

How many sisters do you have? _____ How many brothers do you have? ____

Please complete this table for your brothers and sisters:

Name	Age	Learning problems?	Mental Health difficulties?	Relationship?
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good

Circle any of the following that have been present in **your immediate/extended family** members:

Heart Disease/Attack	Stroke	Cancer	Intellectual Impairment
Learning Problems	Anxiety	Depression	Social Difficulties
ADHD	Autism/Asperger's	Alcoholism	Drug Addiction/Abuse
Bipolar Disorder	Personality Disorders	Jail/Prison	Probation
Suicide	Extended Unemployment	Eating Disorder	Developmental Delays
Tic Disorders	OCD	Schizophrenia	PTSD
Sleep Disorders	Sexual Disorders		

Has how you were treated and raised as a child had more of a positive or negative effect on your personality? Positive Negative

If you circled negative, please explain:

History of Trauma (circle all that apply):

Serious Illness in Family	Sexual Abuse	Victim of Violence
Serious Illness in Child	Exposure to Domestic Violence	Unsafe Neighborhood
Poverty	Child Abuse/Neglect	Homeless
Multiple Caregivers	Foster Care/Adopted	Victim of a Crime

Was the Department of Children and Families (DCF), ever involved with your family as a child?

Yes No

Does you attend a religious organization regularly? Yes No Where_____

Do any close family/friends in the area to provide emotional support to you and your family? Yes No

Were you ever abused or mistreated? Yes No

Current Family History:

Have you ever been married? Yes No How many times? ____

Spouse Name	Date Married	Date Separated/Divorced

Who do you currently live with? _____

Do you currently have a boyfriend/girlfriend? Yes No How long? _____

Circle any problems in your romantic relationships:

Communication	Trust	Commitment	Affair/Cheating	Anger	Control
Physical fights	Yelling	Insults	Affection	Intimacy	Empathy
Making time	Disagree about Money	Disagree about Religion	Disagree about childrearing	Romance	Alcohol/Drug Abuse

Do you have difficulty making friends? Yes No

Do you have difficulty keeping friends? Yes No

Circle any problems in your relationships with friends.

Trust	Hard to think of things to say	Hard to meet people	Hard to open up	Too few friends	Respect
Don't like people	Gossiping	Backstabbing	Empathy	Physical fights	Don't keep in touch
Making time	Arguments	Yelling	Insults	Can't count on them	Alcohol/Drug Abuse

Do you have any children? Yes No

Name	Age/Grade	Learning problems?	Mental Health difficulties?	Relationship?
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good
		Yes No	Yes No	Poor Fair Good

Parent Time/Custody Schedule with your child(ren): Full Time:_____50/50 Split:_____
Weekends:_____No Contact:_____ Other:_____

Has DCF been involved with your current family? Yes No

If yes, explain:

Developmental History:

Circle any of the following that were problems with your birth or delivery.

Premature	Low Birth Weight	Gestational Diabetes	Jaundice
C-Section	Mom drank alcohol	Mom smoked	Mom used illegal drugs

Circle yes below, if to the best of your knowledge, you met each developmental milestones on time.

Talking? Yes No Walking? Yes No Toilet Training? Yes No

Did you have any speech difficulties? Never As a child Currently

Did you ever receive speech therapy? Yes No If so, when?_____

Have you ever received occupational therapy? Yes No If so, when?_____

Have you ever received physical therapy? Yes No If so, when? _____

Medical History:

Place an "X" in the appropriate range if you have suffered from any of the following:

Medical Disorder	As a child/teenager	As an adult
Chronic Ear Infections		
Cancer		
HIV/AIDS		
Heart Attack		
Concussion		
Seizure/Epilepsy		
Broken Bones		
Chronic Stomach Problems		
Asthma		

Meningitis		
Multiple Sclerosis		
Thyroid Condition		
High Blood Pressure		
Diabetes		
Chronic Fatigue Syndrome		
Chronic Pain/ fibromyalgia		
Heady Injury		
Genetic Disorder		
Other		
Other		
Other		

Have you ever had surgery? Yes No

If Yes, explain

Any visual difficulties? Yes No If Yes, do you wear glasses or contacts?

Any hearing difficulties? Yes No If Yes, do you wear a hearing aid?

Please list any prescription medications that you currently use:

Medication	For What?	Doctor Who Prescribed?

Circle any of the following that you often struggle with:

Headaches	Fainting	Can't fall asleep	Can't stay asleep
Feels shaky	Nausea	Eat too much	Eat too little/No appetite
Stomachaches	Vomiting	Diarrhea	Constipation
Heart racing	Chest pains	Excess sweating	Shallow breathing
Tension	Sore throat	Wake up too early	Don't need sleep/Stay up all night
Hair pulling	Nail biting/picks skin	Shortness of breath	Teeth grinding

Circle any motor difficulties that you have:

Clumsiness	Poor fine motor	Difficulty with balance
Difficulty throwing or catching	Not athletic	Difficulty coordinating movements
Poor Handwriting	Poor balance	Poor muscle tone

Mental Health History:

Circle any of the following which have been an issue for you over the past year:

Irritable	Sad most of the day	Excessively nervous	Unemotional or detached
Poor attention to detail	Paying attention for long periods	Poor organization	Easily distracted
Hard to repeat directions	Fail to finish work	Often loses things	Forgetful
Loss of interest in normally enjoyable activities	Trouble getting to work or appts. on time	Frequent mood changes	Purposefully injures self or cutting self
Mistrustful of others	Think about death	Low self-esteem	Think about suicide
Test anxiety	Impulsive	Social anxiety	Strong beliefs that are unsupported by reality
Sees or hears things that are not present	Fidgets	Restless	Obsessions
Breaks things	Physically aggressive	Phobia with _____	
Flashback of bad memories	Nightmares	Seeing reminders of bad experiences everywhere	Poor concentration
Excessive energy	Hyper	No sex drive	Hyper sexual
Interrupting others	Difficulty remaining quiet	Interrupts others	Hostile
Hard to sit still	Ritual/unusual routines	Lacks Motivation	Withdrawn
Excessive spending	Risky or illegal behavior	Hoarding	Overly dramatic
Anger Management	Poor coping	Inflated self-esteem	Panic Attacks
Lying	Anxious	Bizarre thinking	Procrastination
Feeling on top of the world	Feeling invincible	Can't control worrying	Thoughts come to quickly to keep up
Can't get organized	Loses things easily	No energy/Fatigue	Excessive guilt/shame

Circle any of the following harmful eating behaviors that you struggle with:

Avoids eating in front of others	Induces vomiting after meals	Overly restrictive diet	Exercises right after meals
Uses diuretics	Purposefully fasts	Binge eats	Overly picky eater

Circle any of the following communication or social skills which you struggle with:

Using eye contact to interact with others	Initiating interactions	Enjoying activities with other people	Understanding what people expect in a relationship
Relating to other people's feelings	Explaining experiences	Accepting criticism	Bossiness
Making inappropriate comments	Hard to share or take turns	Holding conversations	Bragging
Overly shy	Misinterprets others' intentions	Inflexible with routines/rules	Adjusting to change
Few close friends	Unusual interests	Social chit-chat	Seeking comfort when upset
Talking with your hands	Using voice intonation to communicate meaning	Talking with your eyes	Insulting people
Yelling	Problems reading facial expressions	Using nonverbal gestures to convey meaning	Difficulty expressing self effectively
Stutters	Using facial expressions to communicate	Understanding personal space	Speaking too loud
Speaking too softly	Speech pacing	Pronunciation of words	Verbal tics
Finding the right words	Uses words that have no meaning or made up words	Describing emotions	Curses excessively
Talks excessively	Talks too little	Talking too much about one topic	Repeating self
Dependent on others	Hard to be alone	Loneliness	

Circle any sensory difficulties that you struggle with:

Irritation with certain fabrics	Sensitive to bright lights	Picky eater	Don't like to be touched
Motor tics	Overly sensitive to loud noises	Don't respond to loud noises	Bothered by low volume noise
Don't like foods with certain textures	Don't like foods with strong tastes	Irritation with tags in clothes	Finding eye contact uncomfortable

Circle any mental health disorder in which you have been diagnosed:

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Impairment	Substance Abuse	Autism/Aspergers
Manic	Oppositional Defiant	Attachment issues	Tic Disorder
Anxiety/PTSD	Conduct Disorder	Personality Disorder	ADHD/ADD
Sleep Disorder	Speech/Language Issues	Developmental Delays	Eating Disorder
Other			

Have you been to counseling before? Yes No If so, when?_____

Who was the therapist? What were you treated for?

Have you ever received inpatient hospitalization for a mental health issue? Yes No

Have you ever been involuntarily hospitalized or Baker Acted? Yes No

Have you ever attempted suicide? Yes No How many times? _____

Drug and Alcohol Use:

Please circle all substances you have used in the past:

Substance	Last Use	Substance	Last Use
Alcohol		cocaine	
PCP (angel dust)		crack cocaine	
marijuana		Hallucinogens (acid, mushrooms)	
amphetamines (speed)		Bath salts	
Spice/synthetic marijuana		Ecstasy/Molly	
methamphetamine (meth)		Opium	
heroin		sleeping pills	
pain killers		Cigarettes	

Have you ever lost a relationship because of drug or alcohol abuse? Yes No

Have you ever lost a job because of drug or alcohol abuse? Yes No

Have you ever been in legal trouble for drug or alcohol abuse? Yes No

Have you ever been treated for drug or alcohol abuse? Yes No

Facility	Year

Legal History:

Have you ever been in trouble with the law? Yes No

If so, when and what happened?

Offense	Date	Length of jail time, probation, or fine

Financial History:

Have you ever filed for bankruptcy? Yes No

Describe your current debt:

Do you own your home or pay rent? Own Rent

Are you able to pay your bills on time? Yes No

If No, explain why?

Do you have a checking account? Yes No

Describe any difficulties that you have maintaining your finances:

Daily Living:

Can you do your own laundry?	Yes	No
Can you drive a car?	Yes	No
Do you have a driver's license?	Yes	No
Do you own/lease your own car?	Yes	No
Can you calculate change?	Yes	No
Can you do your own grocery shopping?	Yes	No
Can you cook for yourself or your family?	Yes	No
Can you bathe and dress yourself without help?	Yes	No

Educational History:

Did you attend Preschool? Yes No If so, where?_____

Did you graduate high school? Yes No When did you graduate? _____

If you have not graduated, when do you expect to? _____

Did you graduate with a standard diploma? Yes No

If you did not graduate high school, did you get a GED? Yes No

Do you intend to go to college? Yes No

Have you attended any college? Yes No Major _____

Did you graduate from college? Yes No Degree _____

If you attended college but did not finish, please explain.

Please list the schools you have attended.

School	City, State	Ages or Years or Grades Attended

Were you in special education/Exceptional Student Education (ESE) in school? Yes No

If so, which grade were you in when you began special education? _____

Circle any disability that you were placed in ESE/special education for:

Reading learning disability	Math learning disability	Writing learning disability	Speech/Language impaired
Hearing impaired	Visually impaired	Emotional disturbance	Intellectual Impairment
Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other Health Impairment
Physical Therapy Impairment	Occupational Therapy Impairment	Developmental Delay	Hospital/Homebound

What types of special classes, accommodations or help with school do/did you receive (mark all that apply)?

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments
Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

Did you ever have to repeat a grade? Yes No If so, what grade(s)?_____

Did you ever get in trouble at school? Yes No If so, when did it start?_____

Did you ever get detentions? Yes No Did you ever get suspended? Yes No

What types of behaviors did you get in trouble for at school?

Did you ever get expelled from school? Yes No What grade were you in?_____

If so, why were you expelled?

Please list any after school activities that you participated in (e.g., clubs, sports)

Currently, what do you like to do for fun?

Job History:

Can you complete a job application without help? Yes No

Circle any of the following that have made it difficult for you to find or keep a job?

Reading	Math	Writing	Medical	Alcohol/Drugs	Mental Health	Legal

In order, please list your job titles, where you worked, how long and why you left?

Job Title	Business Name	How long?	Why did you leave?

At work, do you have difficulty getting along with supervisors? Yes No

At work, do you have difficulty getting along with co-workers? Yes No

At work, do you have difficulty getting along with customers? Yes No

Have you ever been fired from a job? Yes No

If yes, please explain.

What strengths do you offer a job?

What are your weaknesses on the job?

What types of jobs would you like to do in the future?

What types of jobs would you not like to do in the future?

Have you ever done any volunteer work? Yes No Where?