Nexus Behavioral Health PLLC

BACKGROUND QUESTIONNAIRE

CONFIDENTIAL

The following is a detailed questionnaire about development, medical history, and current functioning. This information is necessary to provide a better picture of your abilities as well as any problem areas. Please fill out this questionnaire as completely as you can and bring it with you to your appointment. If filling out as a parent or guardian, please fill out all applicable areas.

GENERAL INFORMATION

Client's Name: _____ Today's Date: _____

Name of person completing this form: _____ Relationship to client: _____

Client's Home Address:

_____

Client's Phone: (H) _____ (W) _____ (Cell) _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Place of Birth: _____ Hand used for writing: ☐ Left ☐ Right

Primary Language: _____ 2nd Language: _____ ☐ Fluent ☐ Not fluent

Medical Diagnosis (if any):(1) _____ (4) _____

(2) _____ (5) _____

(3) _____ (6) _____

Briefly describe problem: _____

_____

_____

Date of accident(s), injury(s), or onset of illness(es): _____

What specific questions would you like answered by this evaluation?

_____

_____

SYMPTOM SURVEY

For each symptom that applies, place a check mark in the box. Add any comments as needed.

PHYSICAL CONCERNS

Motor:

☐ Headaches
☐ Excessive fatigue
☐ Weakness
Location: _____
☐ Problems with fine motor control
☐ Dizziness
☐ Urinary Incontinence
☐ Balance Problems
☐ Tic or strange movements
☐ Tremor or shakiness
☐ Nausea or vomiting
☐ Bowel Problems
☐ Often bump into things
☐ Blackout spells
☐ Other: _____

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Sensory:

☐ Numbness - Location: _____ ☐ Tingling - Location: _____

☐ Difficulty telling hot from cold ☐ Unaware of things on one side of body

☐ Visual Impairment ☐ Problems seeing on one side

☐ Sensitivity to bright lights ☐ Blurred vision

☐ See things that are not there ☐ Brief periods of blindness

☐ Need to squint or move closer to see clearly ☐ Hearing loss

☐ Ringing in ears ☐ Hear strange sounds

☐ Problems with taste sensitivity **(select one)**

☐ Problems with smell sensitivity **(select one)**

☐ Wear glasses **(select one)**

☐ Wear hearing aid **(select one)**

☐ Pain - Average Intensity (0-10): _____ Location: _____ Sensation: _____

COGNITIVE/MOOD CONCERNS

Problem Solving:

☐ Difficulty figuring out problems that most others can do

☐ Difficulty figuring out how to do new things

☐ Difficulty changing a plan or activity when needed

☐ Difficulty planning ahead

☐ Difficulty completing an activity in a reasonable time

☐ Difficulty thinking as quickly as needed

☐ Difficulty doing things in the right order (sequencing)

Language and Math Skills:

☐ Difficulty finding right word ☐ Slurred speech

☐ Odd or unusual speech sounds ☐ Difficulty expressing thoughts

☐ Difficulty understanding what others say ☐ Difficulty understanding what I read

☐ Difficulty writing letters or words (not due to motor problems)

☐ Difficulty with math (e.g., balancing checkbook, making change, etc.)

Nonverbal Skills:

☐ Difficulty telling left from right ☐ Difficulty drawing or copying

☐ Difficulty dressing (not due to motor problems) ☐ Slow reaction time

☐ Problems finding way around familiar places ☐ Parts of my body seem as if they do not belong to me

☐ Difficulty recognizing objects or people ☐ Not aware of time (e.g., day, season, year)

☐ Decline in my musical abilities

☐ Difficulty doing things I should automatically be able to do (e.g., brushing teeth)

Awareness and Concentration:

☐ Highly distractible ☐ Lose my train of thought easily

☐ My mind goes blank a lot ☐ Difficulty doing more than one thing at a time

☐ Become easily confused and disoriented
☐ Tasks require more attention or effort
☐ Don't feel very alert or aware of things

Memory:

☐ Forget where I leave things (e.g., keys, gloves, etc.)
☐ Forget what I should be doing
☐ Forget recent events (e.g., breakfast)
☐ Forget events that happened long ago
☐ More reliant on notes to remember things
☐ Forget facts but can remember how to do things
☐ Forget names
☐ Forget where I am or where I am going
☐ Forget appointments
☐ More reliant on others to remind me of things
☐ Forget the order of events
☐ Forget faces of people I know (when not present)

Mood/Behavior/Personality: **(SELECT ONE)**

☐ Sadness or depression
☐ Anxiety or nervousness
☐ Stress
☐ Sleep problems
☐ Change in energy
☐ Change in appetite
☐ Change in weight
☐ Change in sexual interest
☐ Experience nightmares on a daily/weekly basis
☐ Euphoria (feeling on top of the world)
☐ Feel as if I just don't care anymore
☐ Experiencing lost time
☐ Difficulty being spontaneous
☐ Impulsivity
☐ Increase in anger/aggression
☐ Much more emotional (e.g., cry more easily)
☐ Easily frustrated/irritability
☐ Less inhibited (do things I would not do before)
☐ Lack of interest in pleasurable activities
☐ Thoughts of hurting yourself/others (circle one)

Over the past six months my symptoms have: ☐ Improved ☐ Stayed the same ☐ Worsened

Is there anything you can do (or someone does) that gets the problems to stop or be less intense, less frequent, or shorter? _____

What seems to make the problem worse? _____

Are you experiencing family stress? Describe: _____
_____

Have others commented to you about changes in your thinking, behavior, personality, or mood? ☐ Yes ☐ No
If yes, who and what have they said?
_____

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Are you experiencing any problems or requiring assistance in any of the following? If so, please explain:
Dressing or Bathing_____
Cooking or Cleaning_____
Setting Up or Taking Medication_____
Paying Bills/Making Purchases _____
Driving_____

Any recent falls?_ _How often?_____

Engaged in physical activity/exercise?_____How often per week_____

EARLY HISTORY

You were born: ☐ On time ☐ Prematurely ☐ Late Weight at birth: _____
Were there any problems associated with your birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period afterward (e.g. need for oxygen, convulsions, illness, etc.)? ☐ Yes ☐ No

If yes, describe: _____

Check all that applied to your mother while she was pregnant with you:
☐ Accident
☐ Alcohol use
☐ Cigarette smoking
☐ Drug use (marijuana, cocaine, LSD, etc.)
☐ Poor nutrition
☐ Psychological problems
☐ Medications (prescribed or over the counter) taken during pregnancy
☐ Illness (toxemia, diabetes, high blood pressure, infection, etc.)

Rate your developmental progress as it has been reported to you. Check one description for each area.

	Early	On Time/Average	Late
Walking	☐	☐	☐
Language	☐	☐	☐
Toilet training	☐	☐	☐
Overall development	☐	☐	☐

As a child, did you have any of these conditions:
☐ Attention problems
☐ Learning disability
☐ Clumsiness
☐ Speech problems
☐ Developmental delay
☐ Hearing problems
☐ Hyperactivity
☐ Frequent ear infections
☐ Muscle weakness
☐ Visual problems

MEDICAL HISTORY

Medical problems in addition to the current condition:
☐ Head Injuries
☐ Loss of consciousness
☐ Motor vehicle accidents
☐ Seizure
☐ Stroke
☐ Arteriosclerosis
☐ Dementia
☐ Diabetes
☐ Heart disease
☐Cancer
☐ Back or neck injury
☐ Poisoning

☐ Major surgeries ☐ Psychiatric problems ☐ Thyroid dysfunction
☐ Exposure to toxins (e.g., lead, solvents, chemicals)
☐ Major falls, sports accidents, or industrial injuries
☐ Other brain infection or disorder (meningitis, encephalitis, oxygen deprivation, etc.)
☐ Serious illness/disorder (immune disorder, cerebral palsy, polio, lung, etc.)

Are you currently taking any medication? ☐ Yes ☐ No ***IF YES, BRING IN LIST OF MEDICATIONS***

Are you currently in counseling or under psychiatric care? ☐ Yes ☑ No
If applicable, please list dates and names of professionals who treated you in the past and are treating currently:

_____

_____

Please list all hospitalizations:

Name of Hospital	Date of hospitalization	Length of stay	Diagnosis

SUBSTANCE USE HISTORY

I started drinking at age: ☐ <10 years old ☐ 10-15 ☐ 16-19 ☐ 20-21 ☐ Over 21
I drink alcohol: ☐ Rarely or never ☐ 1-2 days a week ☐ 3-5 days a week ☐ Daily
I used to drink alcohol but stopped. Date stopped: _____
Preferred types of drinks: _____
Usual number of drinks I have at one time: _____
My last drink was: ☐ < 24 hours ago ☐ 24-48 hours ago ☐ Over 48 hours ago

Check all that apply:
☐ I can drink more than most people my age and size before I get drunk.
☐ I sometimes get into trouble (fights, legal difficulty, work problems, conflicts with family, accidents, etc.) after drinking. Please specify: _____
☐ I sometimes black out after drinking.

Please check all the drugs you are now using or have used in the past:

	Presently Using	Used in Past
Amphetamines (including diet pills)	☐	☐
Barbituates (downers, etc.)	☐	☐
Cocaine or Crack	☐	☐
Hallucinogenics (LSD, Acid, etc.)	☐	☐
Inhalants (Glue, Nitrous Oxide, etc.)	☐	☐
Marijuana	☐	☐

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Opiate narcotics (Heroin, Morphine, etc.)	☐	☐
PCP (Angel Dust)	☐	☐
Others (list)	☐	☐

Has use of drugs ever affected you work/school performance or ability to drive? ☐ Yes ☐ No
If yes, which ones? _____
Do you consider yourself dependent on any prescription drugs? ☐ Yes ☐ No
If yes, which ones? _____

Check all that apply:
☐ I have gone through drug withdrawal.
☐ I have used IV drugs.
☐ I have been in drug treatment.

Do you smoke/use tobacco? ☐ Yes ☐ No If yes, amount per day: _____
Do you drink coffee/caffeine? ☐ Yes ☐ No If yes, amount per day: _____

FAMILY HISTORY

The following questions are about your biological mother, father, brothers, and sisters:
Is your mother alive? ☐ Yes ☐ No
If deceased, what was the cause of her death? _____
Mother's highest level of education: _____ Mother's occupation: _____
Does your mother have a known or suspected learning disability? ☐ Yes ☐ No
If yes, describe: _____

Is your father alive? ☐ Yes ☐ No
If deceased, what was the cause of his death? _____
Father's highest level of education: _____ Father's occupation: _____
Does your father have a known or suspected learning disability? ☐ Yes ☐ No
If yes, describe: _____

How many brothers and/or sisters do you have? _____
What their ages? _____
Were there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters? ☐ Yes ☐ No If yes, describe: _____

Please check the issues that have affected close biological family members (parents, brothers, sisters, grand parents, aunt, uncles). Please note who the family member was.

Neurologic disease	**Who**
☐ Alzheimer's disease or senility	_____
☐ Huntington's disease	_____
☐ Multiple Sclerosis	_____
☐ Parkinson's disease	_____

☐ Epilepsy or seizures _____
☐ Other neurologic disease _____

Psychiatric Illness **Who**
☐ Depression _____
☐ Bipolar illness (Manic-Depression) _____
☐ Schizophrenia _____
☐ Other _____

Other Disorders **Who**
☐ Mental Retardation _____
☐ Speech or language disorder _____
☐ Learning problems _____
☐ Attention problems _____
☐ Behavior problems _____
☐ Other major disease or disorder _____

PERSONAL HISTORY

MARITAL HISTORY

Current marital status: ☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed
Years married to current spouse: _____
Dates of previous marriages: From _____ To _____
From _____ To _____
Spouse's name: _____ Spouse's Occupation: _____
Spouse's health: ☐ Excellent ☐ Good ☑ Poor
Number of children:_____ Step children:_____

	Age	Gender
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Who currently lives at home with you? _____
Do any family members have any significant health concerns/special needs? _____

EDUCATIONAL HISTORY

Highest level of education completed: _____
If attended high school, where? _____
If attended college, where? _____
If a high school diploma was not awarded did you complete a GED? ☐ Yes ☐ No
Were any grades repeated? ☐ Yes ☐ No If yes, why? _____
Did you have any problems learning to read, write, or do math? _____
Were you ever in any special classes or did you ever receive special services? ☐ Yes ☐ No
If yes, what grades? _____ or age? _____

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What type of class(es)? _____

How would you describe your usual performance as a student? ☐ A & B ☐ B & C ☐ C & D ☐ D & F

Provide any additional helpful comments about your academic performance: _____

_____

MILITARY SERVICE

Did you serve in the military? ☐ Yes ☐ No If yes, which branch? _____ Dates: _____

Certifications/Duties: _____

_____

Did you serve in war time? ☐ Yes ☐ No If yes, what arena? _____

Did you receive injuries or were you exposed to any dangerous or unusual substances during your service?

☐ Yes ☐ No If yes, explain: _____

Do you have any continuing problems related to your military service? ☐ Yes ☐ No If yes, explain: _____

_____

OCCUPATIONAL HISTORY

Are you currently working? ☐ Yes ☐ No

Current job title: _____ Name of employer: _____

Dates of employment: _____ to _____

Do you see your current work situation as stable? ☐ Yes ☐ No

Current responsibilities: _____

Are you currently experiencing any problems at work? ☐ Yes ☐ No

If yes, describe: _____

Previous employers:

Name	Dates	Duties/position	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RECREATION

Briefly list the types of recreations that you enjoy (e.g., sports, games, TV, hobbies, etc.): _____

_____

Are you still able to do these activities? _____

If not, why not? _____

RECENT TESTS

Check all tests that you have had done recently. Please write in the dates they were done.

TEST	DATE
☐ Angiography	_____
☐ Blood work	_____
☐ CT Scan	_____
☐ MRI	_____

☐ PET Scan _____
☐ SPECT _____
☐ Skull X-Ray _____
☐ EEG _____
☐ Neurological exam _____
☐ Other _____

Identify the physician who is most familiar with your recent problems (e.g. family doctor or intern):

_____

Date of last vision exam: _____
Date of last hearing exam: _____

Have you had a prior psychological or neuropsychological exam? ☐ Yes ☐ No
If yes, please complete the following:
Name of psychologist: _____ Date of exam: _____
Reason for evaluation: _____
Finding of evaluation: _____

Please provide any additional information that you feel is relevant to this referral: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Further Evaluate:

History of SI/HI:
_____

History of Abuse/
Neglect:_____

Disruption or change in sexual
functioning:_____

_____
____

Cultural Preferences/Important Life Events:-
_____