Comprehensive Background Information

Thank you for taking the time to fill out this comprehensive form. This will help me gain a deeper understanding of you, your background, the issues that bring you in to see me, and the factors that may have influenced or caused the issue. Please fill out this form to the best of your ability.

GENERAL INFORMATION Date:_____

Name: _____ Age: _____

Race/Ethnicity:_____ Marital Status: _____

Gender Identity: _____ Sexual Orientation:_____

By whom were you referred? _____

Name of Primary Care Physician: _____

Living Situation: _____ With whom do you live? _____

DESCRIPTION OF PRESENTING PROBLEMS

What is the nature of the problems for which you are seeking help? _____

_____

_____

_____

_____

On the scale below, please indicate the severity of the problems you have described above:
☐Mildly upsetting ☐Moderately upsetting ☐Very severe ☐Extremely severe ☐Incapacitating

When did these problems begin? _____

What seems to worsen these problems? _____

_____

What have you tried that has been helpful? _____

_____

Have you been in therapy or received any professional assistance for these problems? _____

Have you ever been hospitalized for psychological/psychiatric problems? _____

Have you ever attempted suicide? If yes, when? _____

_____

How satisfied are you with your life as a whole?
Not at all satisfied 1 2 3 4 5 6 7 8 9 10 Completely satisfied

How would you rate your overall level of tension/stress during the last month?
Relaxed/no stress 1 2 3 4 5 6 7 8 9 10 Extremely tense/stressed

EXPECTATIONS REGARDING THERAPY

What are you expecting from therapy? _____

_____

_____

How long do you expect for your therapy to last? _____

What qualities do you think your ideal therapist would possess? _____

_____

PERSONAL AND SOCIAL HISTORY

Father: Name: _____Age:_____

Occupation: _____ Health: _____

If deceased, give his age at time of death: ____ How old were you at the time? _____

Cause of death: _____

Mother: Name: _____ Age:_____

Occupation: _____ Health: _____

If deceased, give her age at time of death: ____ How old were you at the time? _____

Cause of death: _____

Siblings: Age(s) of brothers: _____ Age(s) of sisters: _____

Any significant details about siblings: _____

_____

_____

If you were not raised by your parents, who raised you and between what years? _____

_____

Give a description of your father's (or father substitute) personality and his attitude towards you (past and present): _____

_____

_____

_____

Give a description of your mother's (or mother substitute) personality and her attitude towards you (past and present): _____

_____

_____

_____

In what ways were you disciplined or punished as a child? _____

_____

What was your home atmosphere like when you were growing up? _____

_____

_____

Were you able to confide in your parents? _____ Did you feel loved and respected? _____

If you have/had a step-parent, what was your age and what was your relationship like with the step-parent? _____

_____

_____

Check any that applied to you **during your childhood/adolescence**:

☐ Happy	☐ Not enough friends	☐ Eating disorder
☐ Unhappy	☐ School problems	Other: _____
☐ Emotional/behavioral problems	☐ Drug/alcohol use	_____
☐ Medical problems	☐ Sexually abused	_____
☐ Ignored	☐ Severely bullied or teased	_____

BEHAVIORS

Check any of the following behaviors that **apply to you often**:

☐ Overeat	☐ Withdrawal	☐ Take too many risks
☐ Unassertive	☐ Nervous tics	☐ Lazy
☐ Drink too much	☐ Concentration difficulties	☐ Aggressive behavior
☐ Work too hard/much	☐ Avoidance	☐ Crying
☐ Procrastination	☐ Spend too much money	Other: _____
☐ Impulsive reactions	☐ Can't keep a job	_____

How is your free time spent?_____

_____

What kind of hobbies or leisure activities do you enjoy or find relaxing?_____

_____

THOUGHTS

Check any of the following that you might use to describe yourself:

☐ Intelligent	☐ A nobody	☐ Inadequate	☐ Memory issues
☐ Confident	☐ Useless	☐ Confused	☐ Attractive
☐ Worthwhile	☐ Evil	☐ Ugly	☐ Indecisive
☐ Ambitious	☐ Crazy	☐ Stupid	☐ Suicidal ideas
☐ Sensitive	☐ Morally degenerate	☐ Naïve	☐ Sense of humor
☐ Loyal	☐ Considerate	☐ Honest	☐ Hard working
☐ Trustworthy	☐ Unattractive	☐ Incompetent	☐ Undesirable
☐ Dishonest	☐ Unlovable	☐ Bad thoughts	☐ Untrustworthy
☐ Worthless	☐ Deviant	☐ Conflicted	☐ Other:_____

Are you bothered by thoughts that occur repeatedly? If so, what are those thoughts? _____

_____

_____

What, if any, worries do you have that may negatively affect your mood or behavior?_____

_____

_____

EMOTIONS

Check any of the following feelings that **often apply** to you:

☐ Angry	☐ Fearful	☐ Happy	☐ Hopeful	☐ Bored	☐ Optimistic
☐ Annoyed	☐ Panicky	☐ Conflicted	☐ Helpless	☐ Restless	☐ Tense
☐ Sad	☐ Energetic	☐ Shameful	☐ Relaxed	☐ Lonely	Other: _____
☐ Depressed	☐ Envious	☐ Regretful	☐ Jealous	☐ Content	_____
☐ Anxious	☐ Guilty	☐ Hopeless	☐ Unhappy	☐ Excited	_____

PHYSICAL SENSATIONS

Check any of the following physical sensations that **often apply** to you:

☐ Headaches	☐ Dizziness	☐ Heart palpitations	☐ Muscle tension
☐ Sexual disturbances	☐ Stomach disturbances	☐ Bowel disturbances	☐ Tics
☐ Fatigue	☐ Nausea	☐ Chest pains	☐ Rapid heart beat
☐ Blackouts	☐ Don't like to be touched	☐ Excessive sweating	☐ Other:_____

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health and, if so, please specify:_____

_____

_____

Please list any medications you are currently taking (including any over the counter medications you take regularly):_____

_____

Do you eat three well-balanced meals each day? _____

Do you get regular physical exercise?_____

How many of hours of sleep do you get on an average night?_____

Do you have any issues with initiating or sustaining sleep? If yes, please specify:_____

_____

Have you sustained any head injuries and, if so, please specify:_____

_____

CAREER

What sort of work are you currently doing?_____

Does your present work satisfy you and, if not, please specify why:_____

_____

What kind of jobs have you held in the past?_____

_____

Have you had any difficulties maintaining employment at any time? If yes, please specify:_____

_____

INTERPERSONAL RELATIONSHIPS

Do you make friends easily? _____ Do you keep them?_____

Did you date much during high school?_____ College?_____

How do your friends make you feel about yourself?_____

_____

Please rate the degree to which you generally feel relaxed and comfortable in social situations:
Very relaxed 1 2 3 4 5 6 7 8 9 10 Very anxious

Do you have friends with whom you feel you can share your most private thoughts? _____

Committed Relationship (if applicable)

Marital status:_____ Length of current relationship:_____

How long did you know your partner before you began dating?_____

What is your partner's age?_____ What is their occupation?_____

Describe your partner's personality:_____

_____

What do you like the most about your partner? _____

_____

What do you like least about your partner? _____

_____

On the scale below, please indicate how satisfied you are in your relationship:
Very dissatisfied 1 2 3 4 5 6 7 8 9 10 Very satisfied

How do you get along with your partner's family?
Very poorly 1 2 3 4 5 6 7 8 9 10 Very well

How do you get along with your partner's friends?
Very poorly 1 2 3 4 5 6 7 8 9 10 Very well

Any significant details about previous relationships?_____

_____

How many children do you have?____ Their ages:_____

Any significant details about your children:_____

_____

SEXUAL HISTORY

Describe your parents' attitude towards sex. Was sex discussed in your home when you were growing up?_____

_____

When and how did you derive your first knowledge of sex? _____

_____

When did you first become aware of your own sexual impulses?_____

_____

Have you ever experienced any anxiety or guilt arising from sex or masturbation? If yes, please specify:_____

Have you ever encountered uncomfortable or unwanted sexual experiences? If yes, please specify:_____

Any relevant details about any sexual experiences?_____

_____

Is your present sex life satisfactory? If no, please specify why:_____

_____

SUBSTANCE USE

Alcohol: Do you currently consume alcohol? _____ If no, have you in the past? _____

If yes, how much/often: ____ (drinks) _____(daily/weekly/monthly/yearly)

Has your use of alcohol created any problems? If yes, please specify: _____

_____

Marijuana: Do you currently use marijuana? _____ If no, have you in the past? _____

If yes, how much/often: _____ (times) _____(daily/weekly/monthly/yearly)

Has your use of marijuana created any problems? If yes, please specify: _____

_____

Other substances: Do you currently use any other substances? If yes, please specify:_____

_____

If no, did you in the past (please specify which substances)?_____

If yes, how much/often: _____ (times) _____(daily/weekly/monthly/yearly)

Has your use of substances created any problems? If yes, please specify: _____

_____

MISCELLANEOUS

Please provide any additional information you think that your counselor should be aware of: