The Office of
James G. Wellborn, Ph.D.
Child, Adolescent & Family Psychologist

Adult Background Information

Please complete **EVERY SECTION** of this questionnaire about the person receiving treatment. This information is very important for developing a complete understanding of areas that can influence most problems. This and all other information you provide is confidential and private. This information is only for Dr. Wellborn's use. Any unanswered sections will require taking valuable time out of the first meeting to complete this paperwork.

GENERAL INFORMATION

Client's Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

SS# _____-____-_____ Age _____ Sex _____ Marital Status: _____ email:_____

Emergency Contact:_____ Phone:_____

Physician _____ Telephone (___)_____

Physician's Address _____

City _____ State _____ Zip _____

I understand that this physician may be contacted. ☐ Yes _____ (Initial) ☐ No _____ (Initial)

I. **REASONS FOR SEEKING HELP**

Please give a complete statement below of your concerns and any concerns expressed by family or others that led to your seeking treatment. Begin by describing the most important concern first.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

How long have you been concerned about these problems? _____

Please mark all of the following descriptions that apply to you now or in the past.

Now	Past		Now	Past	
☐	☐	Alcohol Abuse	☐	☐	Tension and Stress
☐	☐	Drug Abuse	☐	☐	Crying Spells
☐	☐	Arrests	☐	☐	Fears
☐	☐	Sleep Problems	☐	☐	Loneliness
☐	☐	Nightmares	☐	☐	Suicidal Thoughts or Attempts
☐	☐	Sexual Problems	☐	☐	Sexually Abused
☐	☐	Appetite Changes	☐	☐	Threats or Attempts to Harm Others
☐	☐	Weight Changes	☐	☐	Obsessions
☐	☐	Anger Outbursts	☐	☐	Difficulty Concentrating
☐	☐	Depression	☐	☐	Hearing Voices
☐	☐	Anxiety	☐	☐	Suspicions About Others
☐	☐	Physically Abused	☐	☐	Racing Thoughts
☐	☐	Mood Swings	☐	☐	Preoccupation with Physical Problems
☐	☐	Low Energy	☐	☐	Other: _____

II. FAMILY HISTORY

	Self	Spouse
Age	_____	_____
Occupation	_____	_____
Current employer	_____	_____
Last school grade completed	_____	_____
Date of present marriage	_____	_____
Dates(s) of prior marriage(s) and/or divorce(s)	(1) Mar Div (2) Mar Div	(1) Mar Div (2) Mar Div

Learning difficulties:	Self:	☐ Yes	☐ No	If "yes," please describe _____
	Spouse:	☐ Yes	☐ No	If "yes," please describe _____
Behavior problems:	Self:	☐ Yes	☐ No	If "yes," please describe _____
	Spouse:	☐ Yes	☐ No	If "yes," please describe _____
Medical problems:	Self:	☐ Yes	☐ No	If "yes," please describe _____
	Spouse:	☐ Yes	☐ No	If "yes," please describe _____
Alcohol/Drug problems:	Self:	☐ Yes	☐ No	If "yes," please describe _____
	Spouse:	☐ Yes	☐ No	If "yes," please describe _____

Please list children starting with the oldest. (Please include <u>all</u> children--step, ½ , deceased etc.)

Name	Birthdate	Age	Sex	Grade in School

Please list any other people living in your home and briefly describe how they came to live there.

_____

Please indicate which, if any, of your blood relatives have experienced any of the following:

			Relationship to You
1. Learning difficulties (reading, math or writing).	□ Yes	□ No	
2. Attention Deficit Disorder (with or without hyperactivity)	□ Yes	□ No	
3. Excessive alcohol and/or drug use	□ Yes	□ No	
4. Emotional problems	□ Yes	□ No	
5. Seizure disorder	□ Yes	□ No	
6. Migraine headaches	□ Yes	□ No	
7. Allergies	□ Yes	□ No	
8. Legal problems	□ Yes	□ No	

III. DEVELOPMENTAL HISTORY

A. Did your biological mother experience any complications during pregnancy (e.g., hospitalization, threatened miscarriage, infections, operations, illnesses, alcohol or drug use, cigarette use, etc.)

□ No □ Yes (Please describe _____)

Length of pregnancy: □ Full Terrn □ Premature (__ weeks old at birth) □ Late (__ weeks old at birth)

B. Father: Any pertinent medical/cigarette/drug use _____

C. Delivery: □ Normal □ Complications (Please describe _____)

D. Infancy-Toddler period (1-24 mos.)

	No	Yes	Very Much
Colic	□	□	□
Active, into everything	□	□	□
Difficulty falling asleep or awakened quickly	□	□	□
Nightmares or sleepwalking	□	□	□
Head-banging	□	□	□
Accident Prone	□	□	□
Sensitive to noises, light, texture, clothing	□	□	□
Breathing problems (e.g., SIDS, etc.)	□	□	□
Easy going, good tempered	□	□	□
Reacted poorly to change in routine	□	□	□
Reacted to new foods, places, or people	□	□	□
Intense and/or loud	□	□	□
Fussy and unhappy	□	□	□

E. Childhood Milestones

Please indicate the age at which you reached the following developmental milestones. If you cannot recall the exact date, please estimate by checking one of the categories at right.

	Age	**Early**	**Average**	**Late**
Spoke first words, said phrases and sentences	_____	□	□	□
Bowel and bladder control	_____	□	□	□
Rode bicycle (without training wheels)	_____	□	□	□
Named colors, said alphabet, began to read	_____	□	□	□

F. Coordination

	Good	Average	Poor
Walking, running, throwing, catching	☐	☐	☐
Shoelace tying	☐	☐	☐
Writing	☐	☐	☐
Athletic abilities	☐	☐	☐

List sports enjoyed _____

List sports in which you excelled _____

G. Adolescent Milestones

	Early	Average	Late	Not Achieved
Disagreed without making things worse	☐	☐	☐	☐
Assertiveness without aggression	☐	☐	☐	☐
Assumed responsibility for behavior	☐	☐	☐	☐
Accurately identified emotions	☐	☐	☐	☐
Established close friendships	☐	☐	☐	☐
Personally responsible for school/grades	☐	☐	☐	☐
Recognized personal strengths	☐	☐	☐	☐
Actions guided by sense of right/wrong	☐	☐	☐	☐
Effective problem solving under stress	☐	☐	☐	☐
Ideas about preferred career path	☐	☐	☐	☐

H. Sleep History

	No	Yes	Very Much
Do you snore when sleeping?	☐	☐	☐
Have you ever stopped breathing during sleep?	☐	☐	☐
Do you regularly fall asleep while watching TV?	☐	☐	☐
Do you have a difficult time waking from sleep?	☐	☐	☐

I. Check the behaviors listed below you exhibited by you DURING CHILDHOOD to an excessive or exaggerated degree when compared to other children.

- ☐ Hyperactivity (high activity level)
- ☐ Poor attention span
- ☐ Impulsivity
- ☐ Low frustration threshold
- ☐ Temper outbursts
- ☐ Interrupts frequently
- ☐ Doesn't listen when spoken to
- ☐ Sudden outbursts of aggression toward other children
- ☐ Withdrawn
- ☐ Acts as though "driven by a motor"
- ☐ Wears out shoes more frequently than siblings
- ☐ Spends free time by him/herself
- ☐ Needs to be entertained during free time
- ☐ Heedless of danger
- ☐ Excessive number of accidents
- ☐ Doesn't learn from experience
- ☐ Poor memory
- ☐ More active than siblings
- ☐ Destroys toys or possessions

IV. MEDICAL AND PSYCHOTHERAPY HISTORY

Date of last complete physical examination _____ Physician _____

Current health concerns or medical problems _____

_____

Immunized against all communicable diseases ☐ Yes ☐ No (If "No," please explain) _____

Complications from any childhood diseases (Please describe) _____

_____

Hospitalizations _____

_____

_____

Head injuries (with or without unconsciousness), seizures, convulsions (with or without fever), coma, meningitis, or encephalitis (Please indicate the age and describe the events in detail) _____

_____

Seizures or "absent" episodes (Please indicate the age these occurred) _____

Allergies or reactions to medication _____

Past Psychiatric Medications: _____

Current Medications:	Drug Name	Dosage	Taken For How Long	M.D.

Psychiatric Hospitalizations:	Year	Reason	Hospital

Prior experience with counseling, psychotherapy, or treatment for chemical dependency

Year____ Agency or Clinician_____ Length of Treatment_____

Year____ Agency or Clinician_____ Length of Treatment_____

Year____ Agency or Clinician_____ Length of Treatment_____

Year____ Agency or Clinician_____ Length of Treatment_____

Reactions to previous psychological care? □ Positive □ Negative _____

_____

V. EMPLOYMENT AND EDUCATIONAL HISTORY

Current employment_____

Has the quality of your work gotten worse recently? □ Yes □ No

If so, for what reason(s)? _____

_____

Have you had a psychological evaluation? □ Yes □ No

(Please bring any psychological test reports with you)

How would you rate your overall level of intelligence? □ Below Average □ Average □ Above Average

List all jobs held in the past 24 months _____

_____

Were you ever told you had a learning disorder: □ Yes □ No If "yes," please describe _____

_____

Are you able to read? □ Yes □ No write? □ Yes □ No

Your grades in school were primarily: □ A's & B's □ B's & C's □ C's & D's □ D's & F's

Please note in each category whether you have had no difficulty, difficulty throughout your school experience, or only temporary difficulty at one time.

	No Difficulty	Difficulty Throughout	Temporary Difficulty
Reading Skills	{ }	{ }	{ }
Math Skills	{ }	{ }	{ }
Handwriting	{ }	{ }	{ }
Staying on task	{ }	{ }	{ }
Interrupting	{ }	{ }	{ }
Fighting	{ }	{ }	{ }
Getting out of seat	{ }	{ }	{ }
Following spoken or written directions	{ }	{ }	{ }
Organizing materials and tasks	{ }	{ }	{ }
Completing work neatly	{ }	{ }	{ }

VI. RELATIONSHIPS, BEHAVIOR, AND ACCOMPLISHMENTS

A. Relationships

	Yes	No
Do you get along well with your work colleagues?	□	□
Do you have a close friend with whom you share personal information?	□	□
Do you experience strife or conflict with your friends or family members?	□	□

Describe briefly _____

_____

Who are the people that provide you with emotional support? _____

B. Religion

How central are religious beliefs to you? □ Very Important □ Kind of Important □ Not Really Important

Do you attend church regularly? □ No □ Yes (If "Yes," what denomination _____)

C. General Behavior

Check the behaviors listed below that would describe your general behavior at present.

□ Hyperactivity (high activity level)
□ Poor attention span
□ Impulsivity
□ Low frustration threshold
□ Temper outbursts
□ Interrupts frequently
□ Doesn't listen carefully to directions
□ Sudden outbursts of aggression toward others
□ Withdrawn
□ Switches from one activity to another
□ Acts as though "driven by a motor"
□ Destroys possessions
□ Spends free time by him/herself
□ Needs to be entertained during free time
□ Heedless of danger or often takes risks
□ Excessive number of accidents
□ Doesn't learn from experience
□ Poor memory
□ Difficulty waiting in lines
□ Trouble finishing things you start
□ Easily distracted

D. Interests and Accomplishments

What do you enjoy doing most? _____

_____

What do you dislike doing most? _____

_____

Please list any accomplishments of which you are particularly proud: _____

_____

What are your strengths, special skills, or abilities? _____

☐ Kind	☐ Sense of Humor	☐ Compassionate
☐ Generous	☐ Athletic	☐ Gentle
☐ Hard Working	☐ Dependable	☐ Helpful
☐ Persistent	☐ Interested in Relationships	☐ Independent
☐ Attractive	☐ Dedicated	☐ Trustworthy
☐ Tough	☐ Good Hearted	☐ Up-beat & Positive
☐ Ambitious	☐ Family-oriented	☐ Good with people
☐ Energetic	☐ Passionate	☐ Intelligent
☐ Thoughtful	☐ Insightful	☐ Street smart
☐ Open-minded	☐ Accepting of others	☐ Loyal
☐ Creative	☐ Mechanically-oriented	☐ Sincere

E. Diet and Physique

How many caffeinated (colas, coffee, etc.) drinks do you consume in a typical day? _____

Do you take daily multi-vitamins ☐ Yes ☐ No

Describe your appetite: ☐ Good ☐ Picky Eater ☐ Poor Appetite ☐ Overeat

What do you eat for snack foods in a typical day? _____

_____

How would you describe your body type?

☐ Very Thin ☐ Thin ☐ Average ☐ Overweight ☐ Very Overweight

Describe the exercise you get during a typical week: _____

VII. LEGAL HISTORY

Have you been involved with the law? ☐ Yes ☐ No If "yes," please describe _____

_____

Number of arrests or charges filed _____

Please list any charges that have been associated with these arrests.

Year _____ Charges _____

Year _____ Charges _____

Year _____ Charges _____

Please list any lawsuits, divorce actions, child custody actions, or any other legal actions currently pending that relate you:

_____

VIII. OTHER FACTORS

Describe any factors not covered in this form that you think are important for me to understand you well.

_____

_____