Anan & Associates

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ADULT BACKGROUND QUESTIONNAIRE

NAME : _____ **DATE :** _____

Birth date : _____ **Gender :** ☐ Male ☐ Female

Address : _____ **City :** _____ **Zip Code :** _____

Primary Physician & Address : _____

Who referred you to Anan & Associates? _____

Employment Status :

☐ Employed ☐ Employed/Student ☐ Student ☐ Unemployed

Employer: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

I permit Anan & Associates to contact me via phone using the following phone number(s) :

**do not include if unacceptable to leave message*

Home _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Home _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Cell _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Cell _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Work _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Work _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Other Phone: _____ Specify: _____

I permit Anan & Associates to contact me via email using the following email address(es) :

Email _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Email _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Email _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Name and contact information of person responsible for the bill :

_____

Please list all people currently living in your household:

Name	Relationship to You	Age

If English is not the primary language spoken in the home, what language is used and how often?

_____

PRESENTING PROBLEM

Please briefly describe your current difficulties :

When was the problem first noticed or how long has it been a concern?

What seems to *help* the problem?

What seems to make the problem *worse*?

Have you received evaluation or treatment for the current problem or similar problems*? ☐ Yes ☐ No

*If **yes**, when and with whom?

Are you on any medication at this time*? ☐ Yes ☐ No

*If **yes**, please list the **name** and **daily dosage** of the medication(s) you are currently taking below :

SOCIAL & FAMILY HISTORY

Please check next to any of the following items that you have concerns about:

- ☐ Peer Relationships
- ☐ Martial/Significant other
- ☐ Social Support Networks
- ☐ Hobbies/Interests
- ☐ Relationships with your children
- ☐ Sexual Issues
- ☐ Other problems (*please describe*) _____

_____

FAMILY SOCIAL HISTORY

Mother's name : _____ **Age :** _____

Highest Level of Education : _____ **Employment :** _____

Father's name: _____ **Age** : _____

Highest Level of Education: _____ **Employment:** _____

Are your parents :

☐ Married ☐ Separated ☐ Divorced ☐ Other (*please specify*) : _____

Number of Siblings & their ages: _____

_____

How would you describe your relationship with your family/siblings? :

☐ Poor ☐ Fair ☐ Good ☐ Excellent

- History of Abuse/Trauma

Have you ever experienced any* :

☐ Physical abuse ☐ Sexual Abuse/Assault ☐ Emotional Abuse ☐ Abandonment/Neglect

*If **yes**, was it reported to the authorities? _____

EDUCATIONAL HISTORY

Please check next to the highest level of education you have competed :

- ☐ Did not graduate high school
- ☐ High School diploma
- ☐ GED
- ☐ Some College (*no degree*)
- ☐ Associates degree
- ☐ Bachelors degree
- ☐ Graduate/Doctoral degree
- ☐ Academic Certificate

Did/do you have any behavioral or learning issues*? ☐ Yes ☐ No

*If **yes**, please explain :

_____

_____

_____

Have you ever been held back in a grade*? ☐ Yes ☐ No

*If **yes**, what grade and why?

_____

_____

_____

DEVELOPMENTAL HISTORY

- PREGNANCY

During pregnancy, did your mother ever :

Take any type of medication? ☐ Yes ☐ No *If **yes**, what kind?* _____

Smoke Ciggarettes? ☐ Yes ☐ No *If **yes**, how many cigarettes/day?* _____

Drink alcoholic beverages? ☐ Yes ☐ No *If **yes**, how much per day?* _____

Use recreational drugs? ☐ Yes ☐ No *If **yes**, what kind & how often?* _____

- DELIVERY, BIRTH, GROWTH & DEVELOPMENT

Were forceps used during delivery? ☐ Yes ☐ No

Was a Cesarean section performed? ☐ Yes ☐ No

If **yes, for what reason?* _____

Were there any birth defects or complications? ☐ Yes ☐ No

If **yes, please describe*: _____

Were you premature? ☐ Yes ☐ No *If **yes**, by how many weeks?* _____

What was your birth weight? ___ lbs ___ oz

Were there any feeding problems*? ☐ Yes ☐ No

If **yes, please describe*: _____

Were there any sleeping problems*? ☐ Yes ☐ No

If **yes, please describe*: _____

Were there any problems in your growth and development during the first few years*? ☐ Yes ☐ No

If **yes, please describe*: _____

_____

MEDICAL HISTORY

Do you have any food or medication allergies*? ☐ Yes ☐ No

*If **yes**, please list/describe below :

_____

_____

_____

How would you describe your current general heath?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

When was the last time you had comprehensive lab work done? _____

When was your last physical exam? _____

Please check below next to any illness or condition that you have had :
If possible, please also include the approximate date (or age) of the illness

	Date(s) or age(s)		Date(s) or Age(s)
☐ Broken bones	_____	☐ Severe headaches	_____
☐ Head injury	_____	☐ Dizziness/fainting	_____
☐ Other serious injury	_____	☐ Extreme tiredness	_____
☐ Seizures	_____	☐ Heart problems	_____
☐ Asthma	_____	☐ Bone/joint disease	_____
☐ Hospitalizations	_____	☐ Diabetes	_____
☐ Surgeries	_____	☐ Cancer	_____
☐ Hearing/ear problem	_____	☐ Bleeding problem	_____
☐ Vision/eye problem	_____	☐ Suicide attempt	_____

☐ Other health problem(s) :

Please describe, including date(s) or age(s) if possible _____

_____

_____

FAMILY MEDICAL HISTORY

Please check next to any illness or condition that any member of your family has had :
Please also include the family member's relationship to you

		Relationship to you			Relationship to you
☐	Alcoholism	_____	☐	Drug abuse	_____
☐	ADD/ADHD	_____	☐	Learning disability	_____
☐	Schizophrenia	_____	☐	Mental Retardation	_____
☐	Bipolar Disorder	_____	☐	Autism Spectrum	_____
☐	Anxiety Disorder	_____	☐	Depression	_____

☐ Other mental health disorder(s) :

Please describe, including family member relantionship(s) to you _____

_____

_____

SUBSTANCE USE HISTORY

Do you use Nicotine*? ☐ Yes ☐ No

*If **yes**, please specify (*e.g., Cigarettes/Cigars/Pipe, chewing tobacco, etc*): _____

Amount/day: _____ How long have you used Nicotine? _____

Do you use Alcohol*? ☐ Yes ☐ No

*If **yes**, how **frequently** do you use alcohol (ex: *2-3 nights/week*), and **how much** alcohol do you typically consume *(e.g., 1-2 glasses of wine/night)*:

_____

How long have you used Alcohol? _____

Do you use Marijuana*? ☐ Yes ☐ No

*If yes, How often do you use?: _____

How long have you used Marijuana? _____

Do you use any other drug(s)*? ☐ Yes ☐ No

*If **yes**, what drug(s) do you use? _____

How **frequently** do you use (ex: *2-3 days/week*), and **how much** do you typically use (ex: *amount/day*)?:

_____

How long have you used? _____

When was the last time you used? _____

OTHER INFORMATION

What are some of your favorite activities?

1. _____
2. _____
3. _____
4. _____
5. _____

What are some activities you would like to engage in more often than you do at present?

1. _____
2. _____
3. _____

What activities do you like least?

1. _____
2. _____
3. _____

THANK YOU FOR TAKING THE TIME TO HELP US GET TO KNOW YOU BETTER

Please use the remaining space on this form to provide Anan & Associates any additional information that you feel would be helpful and/or important for us to know as we work with you through our therapy services:

_____

_____

_____

_____

_____

_____