NeuroClinic
and Assessments
659 Ridgeview Dr., McHenry, IL 60050
815-344-1999
Fax: 815-516-5171
www.myneuroclinic.com

CONFIDENTIAL BACKGROUND QUESTIONNAIRE - THERAPY

In preparation for your psychological treatment, please complete the questions below. Please answer as completely and with as much detail as possible. Feel free to use additional pages if necessary. Although it is preferred that you complete the questionnaire yourself, you may ask a spouse, relative or significant other for help if needed. Please answer all questions which pertain to you. I would like to review this before our first meeting, but if you don't finish, you may bring this to your first appointment. You may fax this to me at the above listed number, mail to the above address to my attention, or email to me directly at:

Dr. Kelly Gustafson: drgustafson@myneuroclinic.com
Nicole Perry: nperry@myneuroclinic.com

NAME: _____

GENDER: M F other: _____ DOB: _____

PREFERRED PHONE NUMBER: _____ Ok to leave message? Y N

REFERRED BY: _____

If another person assisted in filling out this form, please enter their information below:

NAME: _____

RELATIONSHIP TO PATIENT: _____

PRESENTING PROBLEM

WHAT IS YOUR REASON FOR SEEKING THERAPY? _____

_____

_____

HOW LONG HAS THIS BEEN A PROBLEM? _____

PERSONAL HISTORY

EDUCATION (highest achieved): _____

PLEASE LIST YOUR PERSONAL STRENGHTS: _____

RELIGIOUS AFFILIATION (or none): _____

If affiliated with a religion, how often do you attend services? never _____ sometimes ____ regularly _____

MARITAL HISTORY

CURRENTLY MARRIED? Y N If not married, significant other? Y N

SPOUSE/SIGNIFICANT OTHER'S NAME: _____ AGE: _____

SPOUSE/SIGNIFICANT OTHER'S OCCUPATION: _____

SPOUSE/SIGNIFICANT OTHER EXPERIENCING CURRENT HEALTH PROBLEMS? Y N

If yes, please explain the health concerns he/she is experiencing: _____

_____

HOW LONG HAVE YOU BEEN WITH SPOUSE/SIGNIFICANT OTHER? _____

Date of marriage, if applicable: _____

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP: _____

_____

_____

PREVIOUS MARRIAGES? Y N If yes, how many? _____

Dates of any previous marriages, divorces or deaths: _____

CHILDREN

1) Name: _____ Age: _____ Highest Education: _____

Employment: _____ Living at home? Y N

2) Name: _____ Age: _____ Highest Education: _____

Employment: _____ Living at home? Y N

3) Name: _____ Age: _____ Highest Education: _____

Employment: _____ Living at home? Y N

4) Name: _____ Age: _____ Highest Education: _____

Employment: _____ Living at home? Y N

FAMILY HISTORY

FATHER'S NAME: _____ LIVING? Y N

If no, year of death? _____ Cause of death? _____ If yes, current age? _____

Occupation: _____

Describe your relationship with your father: _____

_____

MOTHER'S NAME: _____ LIVING? Y N

If no, year of death? _____ Cause of death? _____ If yes, current age? _____

Occupation: _____

Describe your relationship with your mother: _____

_____

SIBLINGS (include full, half and step):

1) Name: _____ Age: _____ Living? Y N

If no, cause of death? _____

Describe your relationship: _____

2) Name: _____ Age: _____ Living? Y N

If no, cause of death? _____

Describe your relationship: _____

3) Name: _____ Age: _____ Living? Y N

If no, cause of death? _____

Describe your relationship: _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

DATE LAST SEEN: _____ DATE OF LAST COMPLETE PHYSICAL:_____

LIST OF CURRENT MEDICATIONS WITH DOSAGES:

Medication Dosage Reason for taking Side effects you experience

_____

_____

_____

_____

ANY CURRENT HEALTH CONCERNS? _____

LIST HOSPITALIZATIONS:

Date Reason Hospital Treatment received

_____

_____

_____

_____

MENTAL HEALTH HISTORY

HAVE YOU HAD PREVIOUS COUNSELING? Y N

If yes, please provide details below:

Date Reason Therapist name Inpatient or outpatient?

_____

_____

_____

HISTORY OF EMOTIONAL, PHYSICAL OR SEXUAL ABUSE IN YOUR FAMILY? Y N

If yes, please explain: _____

_____

_____

HISTORY OF SUICIDAL THOUGHTS? Y N SUICIDE ATTEMPTS? Y N

If yes, please explain: _____

SUBSTANCE USE HISTORY

ALCOHOL: Never: _____ Past: _____ Current: _____

Frequency/Amount used in past: _____

Frequency/Amount used presently: _____

NICOTINE: Never: _____ Past: _____ Current: _____

Frequency/Amount used in past: _____

Frequency/Amount used presently: _____

CAFFEINE: Never: _____ Past: _____ Current: _____

Frequency/Amount used in past: _____

Frequency/Amount used presently: _____

DRUGS: Never: _____ Past: _____ Current: _____ Type(s): _____

Frequency/Amount used in past: _____

Frequency/Amount used presently: _____

HAVE YOU RECEIVED TREATMENT FOR ANY ABOVE SUBSTANCE? Y N

If yes:
Date Substance Length of treatment time

_____

_____

FAMILY HISTORY OF SUBSTANCE ABUSE? Y N

If yes:
Family member Substance

_____

_____

LEGAL HISTORY

DESCRIBE ANY LEGAL INVOLVEMENT YOU HAVE HAD: _____

_____

HAVE YOU EVER BEEN ARRESTED? Y N If yes, how many times? _____

EMPLOYMENT HISTORY

EMPLOYER: _____ JOB TITLE:_____

How long employed? _____

EMPLOYER: _____ JOB TITLE:_____

How long employed? _____

EMPLOYER: _____ JOB TITLE:_____

How long employed? _____

RETIRED? Y N If yes, when did you retire? _____

CHECK ANY OF THE FOLLOWING WHICH APPLIES TO YOU AT THE PRESENT TIME:

_____ Feeling depressed
_____ Trouble sleeping
_____ Nausea or vomiting
_____ Lack of energy
_____ Feeling panicky
_____ Feelings easily hurt
_____ Relationships problems
_____ Mood swings
_____ Feeling lonely
_____ Problems with friends
_____ Feeling inferior
_____ Sexually acting out
_____ Unable to pray
_____ Physical aggression
_____ Unresolved grief
_____ Easily distracted
_____ Separation/loss/divorce
_____ Poor decision making
_____ Restless/fidgety
_____ Feelings of guilt
_____ Financial problems
_____ Learning disability
_____ Dizziness
_____ Social anxiety/shyness

_____ Poor appetite
_____ Muscle twitching
_____ Weight gain
_____ Fainting spells
_____ Unable to have fun
_____ Flashbacks
_____ Always worried
_____ Fighting/arguing
_____ Stealing
_____ Suicidal thoughts
_____ Lying
_____ No meaning in life
_____ Impatient with people
_____ No sense of peace
_____ Feel like smashing things
_____ Feeling unloved
_____ Impulsivity
_____ Overly sensitive
_____ Feeling rejected/abandoned
_____ Work difficulties
_____ Fast heartbeat
_____ Frequent sweating
_____ Poor social skills
_____ Feeling tense

_____ Constipation
_____ Loss of weight
_____ Headaches
_____ Crying spells
_____ Unable to make decisions
_____ Lacking confidence
_____ Painful memories
_____ Self-harming behaviors
_____ Lack of enjoyment
_____ Problems with parents
_____ Unmotivated
_____ Easily angered
_____ Unable to forgive
_____ Feel like hurting someone
_____ Confused about religion
_____ Poor concentration
_____ Nightmares
_____ Easily excited
_____ Can't hold a job
_____ Feeling anxious
_____ Cold hands/feet
_____ Speech/Language problems
_____ Stomach trouble
_____Difficulty making friends