Date Entered ________ Initials _____
Counselor ______________________

# Center for Biofeedback and Behavior Therapy, LLC

15028 Beltway Dr. • Addison, TX 75001 • Local: (469) 358-1309 • Fax: (972) 386-6700 • www.onlinebiofeedback.com

## Adult Background Information

***Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you in your interview.***

*Name*________________________________________________ *First Visit Date:*______________________
Last First MI

*Home Phone*: ____________________________(***May call***: yes/no ***Message***: yes/no) (circle yes or no)

*Work Phone:* ____________________________(***May call***: yes/no ***Message***: yes/no) (circle yes or no)

*Cell Phone:* _____________________________(***May call***: yes/no ***Message***: yes/no) (circle yes or no)

*Home Address*:____________________________________________________________________________
Street Apt. City State Zip

*Best time/place to contact you*: _______________________ Occupation: ______________________________

*In case of emergency, contact:*____________________________________________________________________
Name Relationship Phone

*Gender*: Male__ Female__ *Date of Birth* __________________________________ Age ____________________

*Ethnicity:* Caucasian___ Africa American___ Hispanic/Latin___ Asian___ Native American___

Bi-racial___ other (explain) ____________________________________________________________________

*Are you currently in counseling elsewhere?* No___ Yes___ (*If yes, do not complete this form until you have met with your counselor)*

*Family members receiving services at this clinic (present or past):*____________________________________

*Are you seeking services because you are a victim of a crime? Did it result in legal action?*_____/______

*Are you currently on probation?* No___ Yes___

*Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)*? No___ Yes___

(If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency ____________________________________________________
Name Address
Phone ___________________ Dates of Service __________________________________(beginning - ending)

*Have you ever been hospitalized for mental health concerns: No___ Yes___ Date:* ___________________
*If yes please explain:*___________________________________________________________________________

*How were you referred to our clinic?* (check those that apply): Physician__ School personnel__
Yellow Pages__ Family member__ Counselor/Psychologist/Psychiatrist__ Friend or Coworker__ Minister__
DPRS__ Flyer__ Newspaper Ads__ Community__ Court__ Self__ Relative__
Other_______________________________________________________________________________

*Person responsible for financial arrangements with our clinic*: ________________________________________

*Educational Level:*
___8th Grade or Below ___High School ___GED (Date__________) ___Trade School
___Some College ___College Graduate ___Master's Degree ___Ph.D. Degree

*Marital Status (indicate all that apply and duration of each, ex. 1965-1985):* Never married_____________________

Married 1_____________ Separated 1___________ Divorced 1__________ Widowed 1___________
Married 2_____________ Separated 2___________ Divorced 2__________ Widowed 2___________
Married 3_____________ Separated 3___________ Divorced 3__________ Widowed 3___________

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly
__1__________2_______________3_____________4____________5

Are you currently involved in a custody dispute: No __ Yes __ (If yes, explain) _________________________
________________________________________________________________________________

*Current living arrangements:* Single___ Significant other___ Single parent with children___ Roommate(s) ___
Married___ Married with children___ Family of origin___ other___________________

**Present Family**
*If married with children, list your family, beginning with the oldest member and include yourself.*

| Name | Age | Gender | Relationship to you (include "step", "half", etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Family of Origin Primary Household (**Family in which you resided the majority of your life)
*List your family members, by household, beginning with the oldest member (include parents and self):*

| Name | Age | Gender | Relationship to you (include "step", "half", etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Family of Origin Second Household** (if applicable)

| Name | Age | Gender | Relationship to you (include "step", "half", etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***Mother's Marital Status*** *(indicate all that apply and duration of each, ex. 1965-1985):* Never married_________________
Married_________ Remarried_________ Divorced_________ Separated_________ Widowed_________
Unknown_________ Number of Marriages_____
***Father's Marital Status*** *(indicate all that apply and duration of each, ex. 1965-1985):* Never married_________________
Married_________ Remarried_________ Divorced_________ Separated_________ Widowed_________
Unknown_________ Number of Marriages_____

# *HEALTH*

*Primary Care Physician:* ____________________________________________
Name

____________________________________________
Address Phone

*Psychiatrist*: ____________________________________________
Name

____________________________________________
Address Phone

*Date of LAST complete physical*_________ Physical *Disability*: yes__ no__ (if yes, explain
) *Chronic Illness*: yes__ no__ (if yes, explain____________________)

*Check the following items for a diagnosis or medication you are now receiving or have received:*

| **Diagnosis** | **Current** | **Past** | **Date of Diagnosis** | **Name of medication** | **Dosage** |
|---|---|---|---|---|---|
| Depression | ________ | ________ | ______________ | ____________________ | ________ |
| ADHD Hyperactive | ________ | ________ | ______________ | ____________________ | ________ |
| ADHD Inattentive | ________ | ________ | ______________ | ____________________ | ________ |
| Learning Disability | ________ | ________ | ______________ | ____________________ | ________ |
| Anxiety/ Nervousness | ________ | ________ | ______________ | ____________________ | ________ |
| Panic Attack | ________ | ________ | ______________ | ____________________ | ________ |
| Manic-Depression (Bipolar) | ________ | ________ | ______________ | ____________________ | ________ |
| Schizophrenia | ________ | ________ | ______________ | ____________________ | ________ |
| Mood/Anger | ________ | ________ | ______________ | ____________________ | ________ |
| Tics | ________ | ________ | ______________ | ____________________ | ________ |
| Insomnia/ Sleeplessness | ________ | ________ | ______________ | ____________________ | ________ |
| Obsessive/ Compulsive | ________ | ________ | ______________ | ____________________ | ________ |
| Addictions | ________ | ________ | ______________ | ____________________ | ________ |
| Convulsions | ________ | ________ | ______________ | ____________________ | ________ |
| Other | ________ | ________ | ______________ | ____________________ | ________ |

*(If you do not know the name and dosage of current medication, please bring the medication to your next session)*

*If you have been diagnosed, who gave the diagnosis?*
Psychiatrist_________ School_________ Family physician_________ Counselor/Psychologist_________
Name________________________________________ Phone #__________________________

*List other medication are you currently taking*
Med.________________________________________ Dosage__________________________

Med.________________________________________ Dosage__________________________

## *CURRENT CONCERNS*

**Indicate severity of up to 10 items (1-mild; 2-moderate; 3-severe) <u>Circle the item that you see as the most significant issue</u>)**

___Adjustment to life changes (changing schools, parent's divorcing, moving, getting married or divorced, aging, etc.)
___Career Dissatisfaction or decisions
___Abuse (physical, emotional, sexual)
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling angry or irritable
___Feeling guilty or shameful
___Feeling sadness or depression or suicidal urges <u>related to grief</u>
___Feeling sadness or depression or suicidal urges <u>NOT related to grief</u>
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (repeated run-ins with the law, etc.)
___Learning/Academic difficulties
___Personal Growth (no specific problem)
___Significant other/spouse relationship
___Parent-Child relationship (discipline, adoption, single parent, etc.)
___Family or Step-family relationship
___Non-family relationship (roommates, friends, co-worker, boss, teacher, etc.)
___Religious or Spiritual concerns
___Sexual functioning concerns
___Sexual identity concern
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Other (explain_______________________________________________)

***Remember to circle the most significant issue.***

*When did you first become concerned about this issue?*_______________________________________

*How have you attempted before now to deal with this issue?*_______________________________________
_______________________________________________________________________________

*Other treatment you have received to address any of the concerns indicated above:* None___
Individual counseling___ Family counseling___ Group counseling___ Couples Counseling___
Hospitalization___ Other (explain)_______________________________________________

*Anything else you think we need to know?* _______________________________________

*What is the one thing I need to know to help you today*? _______________________________________

## *FAMILY HISTORY/EXPERIENCES*

(**For each of the following items that apply, write in your <u>approximate age</u> at the time it occurred):**

*Raised by:* Natural parents___ Single natural parent___ Grandparents___ Adoptive parent(s)___ Natural and step-parent___ Foster parents___ Institution___ Relatives___ Other_______________

*Stressors in the Family:* Parents fighting frequently___ Parents divorced___ Financial problems___ Family member's disability or major accident or illness___ Chronic illness of family member___ Moved a lot___ Family member absent (explain)________________ Death of significant person___ Family member suicide(explain)_______________ ________________ Family member emotional problems (explain) ______________________________
Other (explain) ______________________________

*History of learning, emotional, behavioral problems:* yes__ no__ (If yes, please explain _______________
_______________________________________________________________________________

*History of alcohol/drug/substance abuse*: yes__ no__ (If yes, please explain ___________________________
_______________________________________________________________________________

*History of family violence:* yes___ no___ (If yes, please explain ________________________________________________ ____
____________________________________________________________________________________________________

*History of criminal activity:* yes___ no___ (If yes, please explain*)*_______________________________________________
____________________________________________________________________________________________________

*Abused* (check all that apply): Physically____ Emotionally____ Sexually____

*Neglected* (check all that apply): Physically____ Emotionally____

*School Problems* (check all that apply): Academic problems____ Severely teased____ Discipline problems____
Unpopular____ Other (explain _________________________________________________________)

*Early Language/Speech Problems* (explain _________________________________________________________)

*Emotional Concerns:* Emotional problems____ Suicidal thoughts____ Suicide attempts____ Loss of energy or fatigue____ Lost weight____ Gained weight ____ Appetite change ____ Heard voices when no one was around ____
other (explain) __________________________________________________________________________

*Behavior Problems* (check all that apply): Misbehaved a lot____ Trouble with the law____ Involved with the juvenile system____ Ran away____ Impulsive____ Alcohol and/or drug use____ Hyperactive____ Attention problems____
Accident-prone____ Frequent arguments____ Taken advantage of____ Temper outbursts____ Slapping, hitting, shoving____ Loner____ Other

*Anxiety Symptoms* (indicate all that apply): Obsessive worrying ____ keyed up, on edge ____ Phobias ____ Irritable ____
Physical symptoms (below) ____ Other _____________________________________________________

*Health/Physical Problems* (check all that apply): Headache (kind) ____ Nervous stomach ____ Diarrhea ____
Bone/joint/muscle ____ PMS ____ Dizziness ____ Shortness of breath without exertion ____
Heart Palpitations ____ Chest pain ____ Surgeries ____ Major illness____ Major accident____ Disability____ Chronic illness____ Hospitalization____ Developmental delay(s)____ Sleep problem____ Bedwetting____ Serious overeating or undereating____ Neurological problems/exam____
Other ______________________________________________________________________________________________

*Dissociative Symptoms (check all that apply):* Walk in sleep____ Trance-like episodes/lost track of time____ Amnesia of large parts of childhood after age 5____ Memories suddenly flashback____
Things of yours that are missing____ Things appear but you don't know origin____

*Trauma/Stressor* (check all that apply): Child separated from parent (how long and when) __________
Death of a significant person____ Death of a pet____ Incarcerated family member____ Sexual Assault____
Victim of trauma (unusual, terrifying experience) ____ Medical____ Natural Disaster____
Other ______________________________________________________________________________________________

*Interpersonal Problems* (check all that apply): Frequent arguments____ Taken advantage of____ Temper outbursts____ Slapping, hitting, shoving, etc., other people____ Loner____ Other_________________________
____________________________________________________________________________________________________

*Specific to Adulthood* (check all that apply): Abortion____ Placing child for adoption____ Parenting/Discipline problems____
Changes in the last 12 months (getting married, becoming a parent, moves, change in employment, etc.)____ Sexual problem (explain)_________________________________________

*Family of Origin Atmosphere (circle the number that best describes how you viewed your family while you were growing up):*

| | | | | | | |
|---|---|---|---|---|---|---|
| Very lenient | 1 | 2 | 3 | 4 | 5 | Very strict |
| Very non-religious | 1 | 2 | 3 | 4 | 5 | Very religious |
| Chaotic | 1 | 2 | 3 | 4 | 5 | Highly structured |
| Few expectations | 1 | 2 | 3 | 4 | 5 | High expectations |
| Inconsistent | 1 | 2 | 3 | 4 | 5 | Consistent |

*Family of Origin Support System (such as church, friends, relatives, school)*

| Hardly any support | 1 | 2 | 3 | 4 | 5 | Considerable support |
|---|---|---|---|---|---|---|

*Family Atmosphere (circle the number that best describes how you view your current family, if applicable):*

| | | | | | | |
|---|---|---|---|---|---|---|
| Very lenient | 1 | 2 | 3 | 4 | 5 | Very strict |
| Very non-religious | 1 | 2 | 3 | 4 | 5 | Very religious |
| Chaotic | 1 | 2 | 3 | 4 | 5 | Highly structured |
| Few expectations | 1 | 2 | 3 | 4 | 5 | High expectations |
| Inconsistent | 1 | 2 | 3 | 4 | 5 | Consistent |

*Family Support System (such as church, friends, relatives, school)*

| Hardly any support | 1 | 2 | 3 | 4 | 5 | Considerable support |
|---|---|---|---|---|---|---|

*Your current use of Computer, VCR, and Television (circle the number of hours that best describes use):*

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

______________________________ ____________________

Patient Signature Date