



Center for Biofeedback and Behavior Therapy

4530 Beltway Rd.
Addison, TX 75001
(469)358-1309
www.cbbt.org

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 _____

Phone _____ Dates of Service _____ Name Address
(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__

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) Circle the item that you see as the most significant issue

- 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 related to grief
- Feeling sadness or depression or suicidal urges NOT related to grief
- 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 approximate age 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