

*Linda Sadoff, LCSW, JD*  
**BACKGROUND QUESTIONNAIRE**

This information will remain confidential within legal limits. If you are requesting couples therapy, both partners should complete this. If there are any questions you are uncomfortable answering, please feel free to pass those over for now.

**IDENTIFYING INFORMATION**

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX:  M  F WHO REFERRED YOU HERE? \_\_\_\_\_

**PRESENTING PROBLEMS**

BRIEFLY DESCRIBE YOUR CURRENT DIFFICULTIES: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**YOUR REPORT OF FEELINGS**

PLEASE CHECK THOSE WORDS WHICH DESCRIBE THE WAY YOU HAVE BEEN FEELING RECENTLY.

RELAXED	OUT OF CONTROL	ANGRY	DIFFICULTY TRUSTING PEOPLE
HIGH	INADEQUATE OR INFERIOR	DEPRESSED	TIRED OR SLEEPY
HAPPY	LONELY	SAD	HEARING OR SEEING THINGS
TENSE	SILLY	HOPELESS	EXPLOSIVE
UPTIGHT	FEARFUL	SUICIDAL	SHORT-TEMPERED
WEAK	RESTLESS	SHY	WORTHLESS
CONFUSED	FRUSTRATED	DISCOURAGED	UNABLE TO SLEEP
DISAPPOINTED	GUILTY	HELPLESS	OTHER:

**EXPECTATIONS FOR TREATMENT**

WHAT DO YOU HOPE TO GAIN FROM YOUR TREATMENT HERE? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**USE OF SUBSTANCES**

CHECK ALL THAT APPLY TO YOU

	CURRENT	PAST	NEVER
ALCOHOL			
STIMULANTS (UPPERS)			
SEDATIVES (DOWNERS)			
OPIATES (HEROIN, ETC.)			
HALLUCINOGENS (MARIJUANA, LSD)			
OTHER:			

IF YOU ARE USING ANY OF THE ABOVE, DO YOU USE . . .  OCCASIONALLY?  DAILY?  WEEKLY?  MONTHLY?

BECAUSE OF YOUR USE OF SUBSTANCES, HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS OR DIFFICULTIES?

	CURRENT	PAST	NEVER
VIOLENCE			
SOCIAL DIFFICULTY			
OCCUPATIONAL DIFFICULTY			
WITHDRAWAL			
SEIZURES			
ALCOHOL BLACKOUTS			
OUI			
OTHER SYMPTOMS			

HAVE YOU OR ANYONE ELSE EVER FELT YOU HAD A PROBLEM WITH ALCOHOL OR OTHER DRUGS?  YES  NO

COMMENTS: \_\_\_\_\_

**TREATMENT HISTORY**

PLEASE LIST ANY TREATMENT YOU HAVE RECEIVED AND EXPLAIN WHERE AND WHEN IT WAS PROVIDED, USE BACK IF NECESSARY

NAME OF TREATMENT PROVIDER (INDIVIDUAL, FACILITY, OR HOSPITAL)	LICENSE OF PROVIDER (MD, LCSW, PSYCHOLOGIST, LCPC, ETC.)	DATES OF CARE (APPROXIMATE)	CONDITIONS DIAGNOSED AND/OR TREATED (FOR EXAMPLE, PLEASE IDENTIFY ALL CONDITIONS, INCLUDING DEPRESSION, ANXIETY, PTSD, EATING DISORDERS, AND OTHERS)

PSYCHIATRIC HOSPITALIZATION \_\_\_\_\_

SUBSTANCE ABUSE OUTPATIENT COUNSELING \_\_\_\_\_

SUBSTANCE ABUSE DETOXIFICATION \_\_\_\_\_

SUBSTANCE ABUSE INPATIENT REHABILITATION \_\_\_\_\_

**MEDICAL HISTORY**

DISEASES (INCLUDE CHILDHOOD) AND OTHER RELEVANT MEDICAL CONDITIONS YOU HAVE HAD, INCLUDING ANY SURGERIES AND HOSPITALIZATIONS:

\_\_\_\_\_

\_\_\_\_\_

NAME OF YOUR PHYSICIAN: \_\_\_\_\_

ADDRESS OF PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

DATE YOU WERE LAST SEEN BY YOUR PHYSICIAN: \_\_\_\_\_

NAME OF CURRENT MEDICATION	WHO PRESCRIBES?	DOSAGE/FREQUENCY	REASON FOR TAKING THIS MEDICATION

**SOCIAL/DEVELOPMENTAL HISTORY**

**YOUR MOTHER:** NAME: \_\_\_\_\_ IF LIVING, GIVE HER AGE: \_\_\_\_\_

IF DECEASED, GIVE DATE: \_\_\_\_\_ CAUSE OF DEATH: \_\_\_\_\_

DESCRIBE HOW YOU HAVE GOTTEN ALONG WITH YOUR MOTHER:

**YOUR FATHER:** NAME: \_\_\_\_\_ IF LIVING, GIVE HIS AGE: \_\_\_\_\_

IF DECEASED, GIVE DATE: \_\_\_\_\_ CAUSE OF DEATH: \_\_\_\_\_

DESCRIBE HOW YOU HAVE GOTTEN ALONG WITH YOUR FATHER:

**YOUR BROTHERS AND SISTERS:** HOW MANY BROTHERS DO YOU HAVE? \_\_\_\_\_ HOW MANY SISTERS DO YOU HAVE? \_\_\_\_\_

DESCRIBE HOW YOU HAVE GOTTEN ALONG WITH YOUR BROTHERS AND SISTERS: \_\_\_\_\_

\_\_\_\_\_

**YOUR STEP-FAMILY:** IF YOU WERE RAISED IN A STEP-FAMILY OR FOSTER FAMILY, PLEASE DESCRIBE THE CIRCUMSTANCES:

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**YOUR CHILDREN:** HOW MANY CHILDREN DO YOU HAVE? \_\_\_\_\_

ANY ADOPTIONS? \_\_\_\_\_

MISCARRIAGES? \_\_\_\_\_

IF ANY CHILDREN ARE DECEASED, PLEASE GIVE DATE AND CAUSE OF DEATH:

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DESCRIBE HOW YOU GET ALONG WITH YOUR CHILDREN: \_\_\_\_\_

**YOUR PARTNER:** NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX:  MALE  FEMALE

DESCRIBE HOW YOU GET ALONG WITH YOUR CURRENT PARTNER: \_\_\_\_\_

**PAST MARRIAGES/SIGNIFICANT PARTNERSHIPS:** BRIEFLY DESCRIBE WHAT WAS SIGNIFICANT ABOUT THESE RELATIONSHIPS FROM YOUR POINT OF VIEW, INCLUDING HOW THEY ENDED.

**SEXUAL ORIENTATION:** HOW DO YOU SELF IDENTIFY? \_\_\_\_\_ HETEROSEXUAL/STRAIGHT, \_\_\_\_\_ LESBIAN, \_\_\_\_\_ GAY, \_\_\_\_\_ BISEXUAL, \_\_\_\_\_ QUESTIONING.

DESCRIBE ANY SIGNIFICANT MEDICAL OR MENTAL HEALTH HISTORY IN YOUR EXTENDED FAMILY: \_\_\_\_\_

IF YOU HAVE EVER BEEN ARRESTED OR INCARCERATED, PLEASE DESCRIBE CIRCUMSTANCES:

IF YOU ARE COMFORTABLE DOING SO, PLEASE PROVIDE THE FOLLOWING INFORMATION. HAVE YOU EVER BEEN ABUSED BY ANOTHER PERSON?  YES  NO IF YES, PLEASE COMPLETE THE FOLLOWING.

TYPE OF ABUSE: \_\_\_\_\_ WHO WAS THE ABUSER? \_\_\_\_\_

WAS THERE VIOLENCE OR ABUSE IN YOUR FAMILY WHEN YOU WERE GROWING UP?  YES  NO

TYPE:  SEXUAL  PHYSICAL  EMOTIONAL PLEASE EXPLAIN: \_\_\_\_\_

WERE YOU EVER ABUSED BY ANYONE OUTSIDE OF YOUR FAMILY?  YES  NO

TYPE:  SEXUAL  PHYSICAL  EMOTIONAL PLEASE EXPLAIN: \_\_\_\_\_

ARE YOU CURRENTLY INVOLVED IN AN ABUSIVE RELATIONSHIP?  YES  NO IF YES, WITH WHOM? \_\_\_\_\_

### **EDUCATIONAL/VOCATIONAL HISTORY**

**EDUCATIONAL:** PLEASE CIRCLE THE HIGHEST GRADE COMPLETED:

GRADE SCHOOL: 1 2 3 4 5 6 7 8 HIGH SCHOOL: 9 10 11 12 COLLEGE: 1 2 3 4 5 6 7 8

DESCRIBE ANY OTHER EDUCATION OR TRAINING: \_\_\_\_\_

IN GENERAL, WHAT WAS SCHOOL LIKE FOR YOU? \_\_\_\_\_

**MILITARY:** WERE YOU EVER IN THE MILITARY?  YES  NO IF YES, YEARS SERVED: \_\_\_\_\_ SERVICE BRANCH: \_\_\_\_\_

DISCHARGE DATE AND STATUS: \_\_\_\_\_

**VOCATIONAL:** YOUR OCCUPATION: \_\_\_\_\_ CURRENT EMPLOYER: \_\_\_\_\_

### **OTHER**

PLEASE TELL ME ANYTHING ELSE YOU FEEL MAY BE IMPORTANT FOR ME TO KNOW AT THIS STAGE:

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