Integrated Health and Behavior, PLLC
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BACKGROUND INFORMATION

If completing this form for another person, please answer as the person would answer.

Name: _____ Nickname: _____
What pharmacy do you use?_____
If you were referred to us, who referred you?_____
What is their phone number?_____

Who lives with you?_____
Status: Single___ Married___ Widowed___ Divorced___ Separated___ Other_____
If you were married previously, please give dates:_____

Please tell us briefly why you want treatment:_____
_____
When did you start having problems?_____
What has helped make it better?_____
What has made it worse?_____
Is this the worst it has been? _____

Have you been in therapy before? Yes □ No □
Whom did you see?_____
_____
When did you see them?_____
Was it helpful? Yes □ No □
Please explain:_____

Do you have any previous psychiatric hospitalizations? Yes □ No □
If so, when and where?_____
Have you ever attempted suicide? Yes □ No □
If so, when and how?_____
If you have a previous diagnosis, what is it? _____

Please list (Psychiatric) medicines you have tried in the past.

Medications:	Dosage:	Side Effects:	Allergies:

Are you currently on any psychiatric medications? Yes □ No □
If so, please list names and doses:

Medication:	Dosage:	Side Effects:

Are you taking any other medications not already listed? Yes □ No □
If so, please list names and doses:

Medication:	Dosage:	Side Effects:

Do you have any allergies to medication? Yes □ No □
If yes, please list: _____

How is your appetite?_____
Do you have an eating disorder or a history of an eating disorder (i.e. throwing up, purging, restricting)? Yes □ No □

How do you sleep?_____
Do you snore or use a CPAP? Yes □ No □
Do you have nightmares? Yes □ No □
How many in the last 2 weeks? (Circle one) 1-3 4-9 10-14

Has anyone ever abused/neglected you in any way? Yes □ No □
If yes, please explain:_____

Do you make and keep friends easily? Yes □ No □

How is your energy level? High □ Low □ Normal

Do you have any problems paying attention or sitting still? Yes □ No □
Do you have problems with staying organized? Yes □ No □
How is your concentration (i.e. can you concentrate on reading, etc.)? _____
_____

Are you currently having any problems at work or school? Yes □ No □
If yes, please explain:_____
What was the last grade you completed in school? _____
How did school go for you?_____
Did you have any learning disabilities?_____
Did you have an IEP or a 504 plan?_____

Are you sad or moody? Yes □ No □
Are you fearful or anxious? Yes □ No □

Do you find yourself having to repeat the same actions (for example: checking, counting or washing)? Yes □ No □
If yes, please explain:_____

Do you have any phobias? Yes □ No □
If yes, what of?_____
Do you have panic attacks? Yes □ No □
If yes, please explain:_____

Have you ever been depressed? Yes □ No □
If yes, please explain:_____
Do you have any problems with your weight? Yes □ No □
Do you cry frequently? Yes □ No □

Have you ever stayed awake for 2 or more days? Yes □ No □
Have you ever been manic? Yes □ No □
Do you have times of intense or excessive spending? Yes □ No □

Do you have tantrums, or are you angry or aggressive? Yes □ No □
Have you ever had violent behavior? Yes □ No □

Do you currently smoke, vape, or use tobacco products? Yes □ No □
Do you drink alcohol currently or have you in the past? Yes □ No □
How much?_____
How often? (Circle one) Daily Weekly Monthly Other: _____
Have you ever used non-prescribed medications? Yes □ No □
Which medications?_____
How much? How often?_____
Have you undergone treatment for substance abuse? Yes □ No □
Do you use marijuana (even medicinally)? Yes □ No □
Are you concerned about the amount of alcohol you drink? Yes □ No □
Have you had a DUI? Yes □ No □
Have you had a blackout? Yes □ No □
Do you have any legal charges related to substance abuse? Yes □ No □
Are firearms in your home? Yes □ No □

Are you presently having any legal issues (for example: suspension, expulsion, arrest, probation, bankruptcy, custody battle)? Yes □ No □
If yes, which issues?_____
Are you involved in any litigation? Yes □ No □
If yes, please explain:_____

Have you ever had a perceptual disturbance (i.e. seeing or hearing something when nothing was there? Yes □ No □
Please explain:_____

Have you purposely cut or hurt yourself in the past? Yes □ No □
If so, how and when?_____

If female, is there any chance you could be pregnant? Yes □ No □

Do you have problems in any of these areas? If so, please circle:

Constitutional	Sweats, weight changes, appetite, often get sick, always cold or hot
Respiratory	Wheezing, breathing, shortness of breath
Cardiac	Dizziness, fatigue, chest pain, limitations on exertion, heart palpitations, difficulty breathing while laying flat
GI	Trouble eating or drinking or swallowing, vomiting, constipation, diarrhea, abdominal pain, blood in stool, heartburn
GU	Soiling during day or night, excessive urination, strong odor to urine
Musculoskeletal	Muscle pain, weakness, rigidity, ticks, tremors, excessive clumsiness
Skin	Rashes, sores, itchy or sensitive skin
ENT	Trouble hearing, ear tubes, abnormal hearing exams, teeth/gum problems
Taste	Trouble with taste, trouble swallowing foods
Vision	Contacts or glasses, problems with seeing clearly, glaucoma
Speech	Stuttering, unclear speech, gone to speech therapy
Neurological	Weakness, staring spells, had a neurological evaluation
Gynecological	Breast cancer, ovarian cancer, STD, history of kidney or bladder stone
Endocrine	Problems with pancreas, or with pituitary thyroid or adrenal glands
Immune	Problems with easy bruising

Do you currently have any active medical problems? Yes □ No □
If yes, what are they?_____
Have you had any cardiac problems? Yes □ No □
Do you have chronic pain? Yes □ No □
Have you had a head injury or concussion? Yes □ No □
If so, when?_____
Have you seen any other medical specialist within the last 5 years? Yes □ No □
If so, for what purpose did you see them?_____
Please list any previous surgeries and year received:_____
_____
_____
Have you ever been hospitalized overnight for a reason other than the ones given above? Yes □ No □
If so, for what cause?_____

Were you adopted? Yes □ No □
Do you have any relatives who have suffered with an emotional disorder or mental illness? Yes □ No □
If yes, please explain:_____
Do you have any relatives who have died by suicide? Yes □ No □
If yes, who and when?_____
Do you have any relatives who have been hospitalized psychiatrically? Yes □ No □
Have any of these relatives received treatment? Yes □ No □
If so, was it helpful? Please explain:_____
_____

Do you have any relatives with sudden death from cardiac arrhythmia? Yes □ No □

Do you have friends that use drugs or are a bad influence? Yes □ No □
What are your friends like? _____
Are you experiencing any relationship problems? Yes □ No □

Occupation:_____ Employer:_____
How long at this occupation?_____ How long at present job?_____
How is work going for you?_____
Military service? Yes □ No □
Are you experiencing any financial problems? Yes □ No □

What things do you find stressful? _____

Who are the people who help you?_____
_____

What are your talents?_____

What are your strengths?_____

What are your goals for treatment?_____
_____

Will you make yourself available for appointments between 9 am and 3 pm? Yes□ No□

Please Rank how often you have been bothered by any of the following problems in **the last 2 weeks**.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

The following questions are for children and adolescents only:

How much did your child weigh at birth (approximately)?_____

Were there any complications with birth (i.e. forceps, breech, labor induced, NICU stay, C-section)?_____

Did your child crawl and walk on time?_____

When did your child start talking?_____

At what age was your child toilet trained?_____

How does your child play with other children?_____

Did or does your child have any sensitivities to fabrics, noise, foods?_____

_____

Did or does your child have any habits, mannerisms, or ticks – i.e. moving hands a certain way, flapping hands, walking on toes, etc?_____

_____

Did or does your child have any unusual interests?_____

_____

Does your child have any unusual storage habits (i.e. hiding or hoarding food, etc.)?___

_____

How is your child's behavior/temperament (ex: energetic, easy to soothe, etc)?_____

_____

Do you consider your child soft hearted or hard hearted?_____

Why?_____

By my signature below, I attest that the above answers are true and correct to the best of my knowledge:

Signed:

_____

Name Printed:

_____

Date: _____