

Background History Questionnaire

GENERAL INFORMATION Name: _____ Date: _____

Height: _____ Wt: _____ Place of Birth: _____ Religion: _____

Do you have a family physician? Yes No

Name of family physician: _____ Telephone Number: _____

Marital Status (Check One): Single Engaged Married Separated Divorced

Widowed Living with someone Remarried: How many times? _____

Cabin do you live in: House Room Apartment Other: _____

With whom do you live? (Check all that apply): Self Parents Spouse Roommate

Child (ren) Friend (s) Others (specify): _____

What sort of work are you doing now? _____

Does your present work satisfy you? Yes No If no, please explain:

What kind of jobs have you held in the past?

Have you been in therapy before or received any professional assistance for your problems? Yes No

Have you ever been hospitalized for psychological/psychiatric problems? Yes No

If yes, when and where?

Have you ever attempted suicide? Yes No

Does any member of your family suffer from an "emotional" or "mental disorder"? Yes No

Has any relative attempted or committed suicide? Yes No

PERSONAL AND SOCIAL HISTORY

Father: Name: _____ Age: _____

Occupation: _____ Health: _____

If deceased, give his age at time of death: _____ How old were you at the time? _____

Cause of death: _____

Mother: Name: _____ Age: _____

Occupation: _____ Health: _____

If deceased, give his age at time of death: _____ How old were you at the time? _____

Cause of death: _____

Siblings: Age(s) of brother(s): _____ Age(s) of sister(s) _____

Any significant details about siblings:

If you were not brought up by your parents, who raised you and between what years?

Give a description of your father' s (or father substitute' s) personality and his attitude towards you (past and present):

Give a description of your mother' s (or mother substitute' s) personality and her attitude toward you (past and present): _____

In what way were you disciplined or punished by your parents?

Give an impression of your home atmosphere (i.e., the home in which you grew up). Mention state of compatibility between parents and between children.

Were you able to confide in your parents? Yes No

Basically, did you feel loved and respected by your parents? Yes No

If you have a stepparent, give your age when your parent remarried: _____

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.? Yes No

If yes, please describe briefly: _____

Scholastic strengths: _____

Scholastic weaknesses: _____

What was the last grade completed (or highest degree)? _____

Check any of the following that apply during your childhood/adolescents:

- | | | |
|--|---|---|
| <input type="checkbox"/> Happy childhood | <input type="checkbox"/> Not enough friends | <input type="checkbox"/> Sexually abused |
| <input type="checkbox"/> Unhappy childhood | <input type="checkbox"/> School problems | <input type="checkbox"/> Physically abused |
| <input type="checkbox"/> Emotional/behavior problems | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Severely bullied or teased |
| <input type="checkbox"/> Legal trouble | <input type="checkbox"/> Strong religious convictions | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Death in family | <input type="checkbox"/> Drug use | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Medical problems | <input type="checkbox"/> Used alcohol | _____ |
| <input type="checkbox"/> Ignored | <input type="checkbox"/> Severely punished | _____ |

DESCRIPTION OF PRESENTING PROBLEMS

Stating your own words the nature of your main problems: _____

On the scale below, please estimate the severity of your problem(s):

- Mildly upsetting Moderately upsetting Very severe Extremely severe Totally incapacitating

When did your problems begin? _____

What seems to worsen your problems? _____

What have you tried that has been helpful? _____

EXPECTATIONS REGARDING THERAPY

In a few words, what do you think therapy is all about? _____

How long do you think your therapy should last? _____

What personal qualities do you think the ideal therapist should possess? _____

BEHAVIORAL ISSUES

Check any of the following behaviors that often apply to you:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Overeat | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Phobic avoidance | <input type="checkbox"/> Outbursts of temper |
| <input type="checkbox"/> Take drugs | <input type="checkbox"/> Suicidal attempts | <input type="checkbox"/> Overspending | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Unassertive | <input type="checkbox"/> Compulsions | <input type="checkbox"/> Can't keep a job | _____ |
| <input type="checkbox"/> On behavior | <input type="checkbox"/> Smoke | <input type="checkbox"/> Take too many risks | _____ |
| <input type="checkbox"/> Drink too much | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Lazy | _____ |
| <input type="checkbox"/> Worked too hard | <input type="checkbox"/> Nervous tics | <input type="checkbox"/> Eating problems | _____ |
| <input type="checkbox"/> Procrastination | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Aggressive behavior | _____ |
| <input type="checkbox"/> Impulsive reactions | <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Crying | _____ |

What are some special talents or skills that you feel proud of? _____

What would you like to start doing? _____

What would you like to stop doing? _____

How is your free time spent? _____

What kind of hobbies or leisure activities do you enjoy or find relaxing? _____

Do you have trouble relaxing or enjoying weekends and vacations? Yes No

If yes, please explain: _____

If you could have any two wishes, what would they be (not more wishes)? _____

FEELINGS SURVEY

Check any of the following feelings that often apply to you:

- | | | | | | |
|------------------------------------|------------------------------------|-------------------------------------|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Angry | <input type="checkbox"/> Fearful | <input type="checkbox"/> Happy | <input type="checkbox"/> Hopeful | <input type="checkbox"/> Board | <input type="checkbox"/> Optimistic |
| <input type="checkbox"/> Annoyed | <input type="checkbox"/> Panicky | <input type="checkbox"/> Conflicted | <input type="checkbox"/> Helpless | <input type="checkbox"/> Restless | <input type="checkbox"/> Tense |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Energetic | <input type="checkbox"/> Shameful | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Lonely | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Envious | <input type="checkbox"/> Regretful | <input type="checkbox"/> Jealous | <input type="checkbox"/> Contented | _____ |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Guilty | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Unhappy | <input type="checkbox"/> Excited | _____ |

List your five main fears:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

What are some positive feelings you have experienced recently? _____

When are you most likely to lose control of your feelings? _____

Describe any situations that make you feel calm or relaxed: _____

PHYSICAL SENSATIONS

Check any of the following physical sensations that often apply to you:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Bowel disturbances | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Pain or burning with urination | <input type="checkbox"/> Tingling | <input type="checkbox"/> Flushes | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Menstrual difficulties | <input type="checkbox"/> Numbness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Skin problems | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tics | <input type="checkbox"/> Dry mouth | _____ |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Burning or itching skin | _____ |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Twitches | <input type="checkbox"/> Chest pains | _____ |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Back pain | <input type="checkbox"/> Rapid heartbeat | _____ |
| <input type="checkbox"/> Sexual disturbances | <input type="checkbox"/> Tremors | <input type="checkbox"/> Don't like to be touched | _____ |
| <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Blackouts | _____ |
| | <input type="checkbox"/> Hear things | <input type="checkbox"/> Excessive sweating | _____ |

What sensations are:

Pleasant for you? _____

Unpleasant for you? _____

IMAGES

Check any of the following that apply to you:

I often picture myself:

- | | | |
|---|---|--|
| <input type="checkbox"/> Being happy | <input type="checkbox"/> Being talked about | <input type="checkbox"/> Being trapped |
| <input type="checkbox"/> Being hurt | <input type="checkbox"/> Being aggressive | <input type="checkbox"/> Being laughed at |
| <input type="checkbox"/> Not coping | <input type="checkbox"/> Being helpless | <input type="checkbox"/> Being promiscuous |
| <input type="checkbox"/> Succeeding | <input type="checkbox"/> Hurting others | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Losing control | <input type="checkbox"/> Being in charge | _____ |
| <input type="checkbox"/> Being followed | <input type="checkbox"/> Failing | _____ |

I have:

- | | |
|--|--|
| <input type="checkbox"/> Pleasant sexual images | <input type="checkbox"/> Seduction images |
| <input type="checkbox"/> Unpleasant childhood images | <input type="checkbox"/> Images of being loved |
| <input type="checkbox"/> Negative body image | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Unpleasant sexual images | _____ |
| <input type="checkbox"/> Lonely images | _____ |

Describe a very pleasant image, mental picture, or fantasy: _____

Describe a very unpleasant image, mental picture, or fantasy: _____

Describe your image of a completely "safe place": _____

Describe any persistent or disturbing images that interfere with your daily functioning: _____

How often do you have nightmares? _____

THOUGHTS

Check each of the following that you might use to describe yourself:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Intelligent | <input type="checkbox"/> A nobody | <input type="checkbox"/> Inadequate | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Undesirable |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Useless | <input type="checkbox"/> Confused | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Untrustworthy |
| <input type="checkbox"/> Worthwhile | <input type="checkbox"/> Evil | <input type="checkbox"/> Ugly | <input type="checkbox"/> Attractive | <input type="checkbox"/> Dishonest |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Crazy | <input type="checkbox"/> Stupid | <input type="checkbox"/> Indecisive | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Sensitive | <input type="checkbox"/> Morally degenerate | <input type="checkbox"/> Naïve | <input type="checkbox"/> Suicidal thoughts | _____ |
| <input type="checkbox"/> Loyal | <input type="checkbox"/> Considerate | <input type="checkbox"/> Honest | <input type="checkbox"/> Persevering | _____ |
| <input type="checkbox"/> Trustworthy | <input type="checkbox"/> Deviant | <input type="checkbox"/> Incompetent | <input type="checkbox"/> Good sense of | _____ |
| <input type="checkbox"/> Full of regrets | <input type="checkbox"/> Unattractive | <input type="checkbox"/> Horrible thoughts | humor | _____ |
| <input type="checkbox"/> Worthless | <input type="checkbox"/> Unlovable | <input type="checkbox"/> Conflicted | <input type="checkbox"/> Hard-working | _____ |

What do you consider to be your craziest thought or idea? _____

Are you bothered by thoughts that occur over and over again? Yes No

If yes, what are these thoughts? _____

What worries do you have that may negatively affect your mood or behavior? _____

Strongly disagree Disagree Neutral Agree Strongly agree

I should not make mistakes.	1	2	3	4	5
I should be good at everything I do.	1	2	3	4	5
When I do not know something, I should pretend that I do.	1	2	3	4	5
I should not disclose personal information.	1	2	3	4	5
I am a victim of circumstances.	1	2	3	4	5
My life is controlled by outside forces.	1	2	3	4	5
Other people are happier than I am.	1	2	3	4	5
It is very important to please other people.	1	2	3	4	5
Play it safe; don't take any risks.	1	2	3	4	5
I don't deserve to be happy.	1	2	3	4	5
If I ignore my problems, they will disappear.	1	2	3	4	5
It is my responsibility to make other people happy.	1	2	3	4	5
I should strive for perfection.	1	2	3	4	5
Basically, there are two ways of doing things – the right way and the wrong way.	1	2	3	4	5
I should never be upset.	1	2	3	4	5

INTERPERSONAL RELATIONSHIPS

Friendships

Do you make friends easily? Yes No Do you keep them? Yes No

Did you date much during high school? Yes No College? Yes No

Were you ever bullied or severely teased Yes No

Describe any relationship that gives you:

Joy: _____

Grief: _____

Rate the degree to which you generally feel relaxed and comfortable in social situations:

Very relaxed 1 2 3 4 5 6 7 Very anxious

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts? Yes No

Marriage (or a committed romantic relationship)

How long did you know your spouse/partner before your engagement? _____

How long were you engaged before you got married/committed? _____

How long have you been married/committed? _____

What is your spouse/partner's age? _____ His/her occupation? _____

Describe your spouse/partner's personality: _____

What the like most about your spouse/partner? _____

But do you like least about your spouse/partner? _____

What factors detract from your satisfaction with the relationship? _____

On the scale below, please indicate how satisfied you are with your marriage/relationship:

Very dissatisfied 1 2 3 4 5 6 7 Very satisfied

How do you get along with your spouse/partner's friends and family?

Very poorly 1 2 3 4 5 6 7 Very well

How many children do you have? _____

Please give their names and ages: _____

Do any of your children present special problems? Yes No

If yes, please describe: _____

Any significant details about a previous marriage/relationship? _____

Sexual Relationships

Describe your parents' attitude toward sex. Was sex discussed in your home? _____

When and how did you derive your first knowledge of sex? _____

When did you first become aware of your own sexual impulses? _____

Have you ever experienced any anxiety or guilt arising out of sex or masturbation? Yes No

If yes, please explain: _____

Any relevant details regarding your first or subsequent sexual experiences? _____

Is your present sex life satisfactory? Yes No

If no, please explain: _____

Provide information about any significant homosexual reactions or relationships: _____

Please note any sexual concerns not discussed above: _____

Other Relationships

Are there any problems in your relationships with people at work? Yes No

If yes, please describe: _____

Please complete the following:

One of the ways people hurt me is: _____

I could shock you by: _____

My spouse (or boyfriend/girlfriend) would describe me as: _____

My best friend thinks I am: _____

People who dislike me: _____

Are you currently troubled by any past rejections or loss of a love relationship? Yes No

If yes, please explain: _____

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? Yes No

If yes, please specify: _____

Please list any medications you are currently taking: _____

Do you eat three well-balanced meals each day? Yes No

Do you get regular physical exercise? Yes No

If yes, what type and how often? _____

Please list any significant medical problems that apply to you or to members of your family: _____

Please describe any surgery you have had (give dates): is for _____

Please describe any physical handicap(s) you have: _____

Menstrual History

Age at first period: _____ Were you informed? Yes No Did it come as a shock? Yes No

Are you regular? Yes No Duration: _____ Do you have pain? Yes No

Do your periods affect your moods? Yes No Date of last period: _____

