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## Health Psychology Department

The purpose of this questionnaire is to obtain a comprehensive picture of your background and history. During your interview with Dr. Taylor, you will have an opportunity to discuss concerns in more detail, if needed. You will need to have this form completed prior to your scheduled appointment. Please use black or blue ink.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

How do you identify yourself racially/ethnically? (Please check all that apply.)

- |  |   |
|--|---|
| <input type="checkbox"/> African American/Black                  | <input type="checkbox"/> South Asian                |
| <input type="checkbox"/> American Indian/Alaskan Native          | <input type="checkbox"/> Middle Eastern             |
| <input type="checkbox"/> White/Caucasian/Anglo/European American | <input type="checkbox"/> Native African             |
| <input type="checkbox"/> Asian/Pacific Islander                  | <input type="checkbox"/> Central or South American  |
| <input type="checkbox"/> Hispanic/Latino/Latina                  | <input type="checkbox"/> Other (please list): _____ |

### **Developmental History:**

Were you raised by your biological parents? Yes No

If you were adopted or raised by an individual other than your biological parents, please explain:

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Were there any medical complications when your mother was pregnant with you? Yes No

If yes, please explain:

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Did your mother use any of the following during the pregnancy?

- Alcohol
- Cigarettes or Tobacco
- Street Drugs

### **Social History:**

Where were you born? What other places did you live and for how long did you live there?

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Mother's Name/Age \_\_\_\_\_ Father's Name/Age \_\_\_\_\_  
 Number of brothers \_\_\_\_\_ Number of sisters \_\_\_\_\_

Please list all significant events in your life that you experienced **AS A CHILD** (including divorce, separation, death, serious illness, traumatic events, abuse, special events, etc.).

<u>Event</u>	<u>Age at time</u>	<u>Effect on you</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle all that apply in describing your childhood:

- |          |            |           |            |
|----------|------------|-----------|------------|
| Normal   | Loving     | Poor      | Rebellious |
| Stale    | Advantaged | Close     | Happy      |
| Pleasant | Fun        | Warm      | Depressing |
| Troubled | Hurtful    | Cold      | Scary      |
| Abusive  | Lonely     | Typical   | Upsetting  |
| Chaotic  | Conflicted | Demanding | Neglectful |

Were you ever a victim of any form of abuse, including physical, verbal, emotional, or sexual abuse? Yes No  
 If yes, please explain:

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

**Education History:**

Are you a high school graduate? Yes No GED Year received: \_\_\_\_\_

If No, what was the last grade you completed: \_\_\_\_\_

Reason for not completing high school: \_\_\_\_\_

High School Name: \_\_\_\_\_ City/State: \_\_\_\_\_

On average, what kind of grades did you earn? (Circle one)

Failing	Poor	Average	Good	Excellent
F's	D's	C's	B's	A's

Did you ever repeat a grade? Yes No Which grade and why? \_\_\_\_\_

Did you ever skip a grade? Yes No Which grade and why? \_\_\_\_\_

What was your favorite subject and why? \_\_\_\_\_

What was your least favorite subject and why? \_\_\_\_\_

Were you ever involved in special education, tutoring, or resource services? Yes No

If yes, please explain:

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Did you receive an IEP or academic accommodations? Yes No

Extra-Curricular Activities and Honors: \_\_\_\_\_

Did/do you attend college or a technical school? Yes No

<u>Years</u>	<u>Institutional/School</u>	<u>Area of Study</u>	<u>Degree</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Employment/Occupational History:**

Did/do you serve in the military? Yes No Branch(s): \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Are you a veteran? Yes No

If yes, are you eligible for VA services? Yes No

Were you ever deployed? Yes No

Are you currently employed? Yes No How many hours per week do you work? \_\_\_\_\_

If Yes, Name of Employer: \_\_\_\_\_ Position Title: \_\_\_\_\_ Starting year: \_\_\_\_\_

If No, are you:  
\_\_\_\_\_ Disabled \_\_\_\_\_ Unemployed \_\_\_\_\_ Retired \_\_\_\_\_ Other: \_\_\_\_\_

When you were working, what was your usual occupation? \_\_\_\_\_

If disabled, when did the disability occur? \_\_\_\_\_

What was the cause? \_\_\_\_\_

What benefits do you receive? \_\_\_\_\_

Please list your past employments:

<u>Employer</u>	<u>Position</u>	<u>Length of Employment</u>	<u>Reason for Leaving</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been fired or had trouble keeping jobs? (Please Explain)

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**Medical History:**

Please list any serious illness or injuries you <i>currently have</i> :

Please list any past serious illness or injuries you <i>had in the past</i> :

Current Medications – Please list your **current** medications (or attach a list):

Medication Name	Dosage	Times Per day	Date Started	Reason

Please list any **previous hospitalizations/surgeries** you have had:

Condition	Date	Hospital

Please check any that you have experienced:

- |  |   |
|--|---|
| <input type="checkbox"/> Head Injury             | <input type="checkbox"/> Heart Disease  |
| <input type="checkbox"/> Seizures                | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Vision Problems         | <input type="checkbox"/> High Blood Pressure/Cholesterol                      |
| <input type="checkbox"/> Hearing Problems        | <input type="checkbox"/> Neurological Disorders (Parkinsons, MS, Brain Tumor) |
| <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> Cancer   |
| <input type="checkbox"/> Headaches               | <input type="checkbox"/> Diabetes   |
| <input type="checkbox"/> Motor Vehicle Accidents |   |

Has anyone in your family ever experienced or been diagnosed with:

- |  |   |
|--|---|
| <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> High Blood Pressure/Cholesterol | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Neurological Disorders (Parkinsons, MS, Brain Tumor) |
| <input type="checkbox"/> Thyroid Problems                | <input type="checkbox"/> Diabetes   |

**Mental Health:**

Have you ever seen a Psychiatrist, Psychologist, or Counselor?    Yes    No

If yes, Please describe (who, when, for what problem):

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Have you ever been hospitalized for a mental health illness or crisis?    Yes    No

If yes, Please describe (who, when, for what problem):

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Have you ever been diagnosed with a mental health disorder?    Yes    No

If yes, Please describe:

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Have you ever engaged in any form of self-harm behaviors, including cutting, picking, burning, ingesting or inserting foreign bodies, or hair pulling?    Yes    No

If yes, Please describe:

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Have you ever attempted suicide?    Yes    No

If yes, Please provide important details (age, reason for attempt, method, were you hospitalized following the attempt, etc.):

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Have you ever:

- been prescribed antidepressants, anti-anxiety, or antipsychotic, or mood stabilizing medications? Yes No
- been treated for a mental health issue, self-injurious behaviors, or eating disorders? Yes No
- attempted or threatened to harm yourself or others? Yes No
- heard or seen things that others were not able to hear or see? Yes No
- completed a psychological evaluation or assessment? Yes No

Are you currently experiencing any of the following:

- Depression  Paranoia
- Anxiety  Hallucinations
- Suicidal thoughts  Feeling like your thoughts or feelings are broadcasted to others
- Homicidal thoughts

In the recent past, have you:

Had changes in the way you get along with family members?	Yes No	
Had any changes in mood or personality?	Yes No	
Been less interested in social activities or time with friends?	Yes No	
Been more irritable?	Yes No	
Felt depressed in the last two weeks?	Yes No	
Felt nervous or anxious in the last two weeks	Yes No	

Are there things that make your symptoms better? Yes No

If yes, please describe:

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Are there things that make your symptoms worse? Yes No

If yes, please describe:

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Is there a family history of mental health issues and/or treatment? Yes No

If yes, please describe:

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**Substance Use/Abuse History:**

Have you ever received a drug and alcohol evaluation? Yes No

If yes, please explain:

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Have you ever been in treatment for alcohol or substance abuse problems (i.e., AA, NA, inpatient, outpatient)?  
 Yes No If yes, please describe:

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Alcohol Use:

Do you **currently** drink alcohol? Yes No

Circle all that apply to describing your **current** alcohol use?

Occasional Regular Socially Daily Binge Drinking Alcoholism

Do you drink alcohol in the past? Yes No

Circle all that apply to describing your **past** alcohol use?

Occasional Regular Socially Daily Binge Drinking Alcoholism

Have you ever passed out from drinking? Yes No

Have you ever blacked out from drinking (forgotten details of activities)? Yes No

Have you ever experienced withdrawals from drinking? Yes No

Have you ever experienced a major medical problem from drinking (i.e., vomiting, bleeding, etc.)? Yes No

Do you **currently** smoke cigarettes, vape, or use other tobacco products? Yes No

Describe your **current** smoking habits (type and amount each day): \_\_\_\_\_

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Please complete the following table:

Drug/Substance	Age at first use	Ages of Heavy Use	Age when use stopped	Reasons for Quitting
Alcohol				
Tobacco				
Cigarettes				
Marijuana/Weed				
Synthetic Marijuana (K2/Spice)				
Meth/Crystal/Ice				
Cocaine				
Heroin/Opium/Opiates (Codeine)				
LSD/Mushrooms/PCP				
Ecstasy/Ketamine/Rohypnal/GNB				
Xanax/Valium/Klonopin/Ativan (without a prescription)				
Ritalin/Adderall/etc. (without a prescription)				
Inhalants				
Bath Salts				
Other:				

**Legal History:**

Have you ever been arrested, charged, or cited? Yes No Number of times: \_\_\_\_\_  
Have you ever been charged with a DUI? Yes No Number of times: \_\_\_\_\_  
Have you ever been cited for possession? Yes No Number of times: \_\_\_\_\_

Have you ever been incarcerated? Yes No Number of times: \_\_\_\_\_  
Circle all that apply: Prison Jail Detention Secure Care

<u>Date</u>	<u>Charge</u>	<u>Length of Sentence</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Living Situation:**

Sexual Preference: Heterosexual/Straight Gay/Lesbian Bisexual Trans-sexual Questioning  
Asexual Queer Other: \_\_\_\_\_

Are you: Single Married Widowed Divorced

Are you in a "steady" or "committed" relationship? Yes No

Spouse/Partner's name: \_\_\_\_\_  
How old were you when the relationship began? \_\_\_\_\_  
How long have you been together? \_\_\_\_\_

List all past major relationships or marriages (including long term boy/girlfriends):

<u>Name</u>	<u>Age</u>	<u>Length</u>	<u>Reason the relationship ended</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all your children:

<u>Name</u>	<u>Age</u>	<u>Where do they live?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been the victim, witness, or perpetrator of domestic violence? Yes No  
If yes, please describe:

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



