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TANNER CLINIC

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/ethically? (Please check all that apply.)

____ African American/Black
____ American Indian/Alaskan Native
____ White/Caucasian/Anglo/European American
____ Asian/Pacific Islander
____ Hispanic/Latino/Latina
____ South Asian
____ Middle Eastern
____ Native African
____ Central or South American
____ 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:

_____
_____

Were there any medical complications when your mother was pregnant with you? Yes No
If yes, please explain:

_____
_____

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?

_____
_____
_____
_____
_____
_____
_____

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.).

Event	Age at time	Effect on you

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? _____

Where you ever involved in special education, tutoring, or resource services? Yes No
If yes, please explain:

_____

_____

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

Years	Institutional/School	Area of Study	Degree
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

Employer	Position	Length of Employment	Reason for Leaving

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

_____

_____

Medical History:

Please list any serious illness or injuries you *currently have:*

Please list any past serious illness or injuries you *had in the past:*

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:

____ Head Injury
____ Seizures
____ Vision Problems
____ Hearing Problems
____ Thyroid Problems
____ Headaches
____ Motor Vehicle Accidents
____ Heart Disease
____ Stroke
____ High Blood Pressure/Cholesterol
____ Neurological Disorders (Parkinsons, MS, Brain Tumor)
____ Cancer
____ Diabetes

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

____ Heart Disease
____ High Blood Pressure/Cholesterol
____ Cancer
____ Thyroid Problems
____ Stroke
____ Seizures
____ Neurological Disorders (Parkinsons, MS, Brain Tumor)
____ Diabetes

Mental Health:

Have you ever seen a Psychiatrist, Psychologist, or Counselor? Yes No
If yes, Please describe (who, when, for what problem):

Have you ever been hospitalized for a mental health illness or crisis? Yes No
If yes, Please describe (who, when, for what problem):

Have you ever been diagnosed with a mental health disorder? Yes No
If yes, Please describe:

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:

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.):

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:
_____
_____
_____
_____

Are there things that make your symptoms worse? Yes No
If yes, please describe:
_____
_____
_____
_____

Is there a family history of mental health issues and/or treatment? Yes No
If yes, please describe:
_____
_____
_____
_____

Substance Use/Abuse History:
Have you ever received a drug and alcohol evaluation? Yes No
If yes, please explain:
_____
_____

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

_____

_____

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): _____

_____

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

Date	Charge	Length of Sentence
_____	_____	_____
_____	_____	_____
_____	_____	_____

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):

Name	Age	Length	Reason the relationship ended

Please list all your children:

Name	Age	Where do they live?

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

_____
_____
_____
_____

Religious/Spirituality:

Religious preference or affiliation: _____

Describe your religious/spiritual experience within your home life:

_____
_____
_____
_____

How important was religion/spirituality to your family growing up?

Not at all Important Somewhat Important Very Important Essential

How important is religion/spirituality to you?

Not at all Important Somewhat Important Very Important Essential

Please use the space below to provide Dr. Taylor a brief understanding of why you are seeking treatment and some information about your treatment goals:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please use the space below to provide any other information you believe is important for Dr. Taylor to know.

_____
_____
_____
_____
_____
_____
_____
_____