Woodview Psychology Group, LLC
70 E. 91st Street, Suite 210, Indianapolis IN 46240

ADULT BACKGROUND INFORMATION FORM

Patient's Name:_____ Date of Birth:_____ Gender: ☐Male ☐Female

Marital Status: ☐Single ☐Married* ☐Separated* ☐Divorced* *How long?_____

Place of Birth: _____

PRESENTING PROBLEMS

What concerns or problems, including symptoms, convinced you to seek help now?

_____
_____
_____
_____
_____

How long has this been a problem? _____
Have you been treated for this problem before? ☐yes ☐no
If yes, who treated you? _____
These problems are: ☐mildly upsetting ☐moderately severe ☐very severe ☐totally incapacitating

FAMILY INFORMATION

Spouse/Significant Other: _____
Children (names & ages): _____

EDUCATION

Highest degree earned: _____ School: _____

JOB HISTORY

Current occupation: _____ Years on the job: _____
Previous occupation: _____ Years on the job: _____

ALCOHOL/DRUG USE/ABUSE

☐ Abstain ☐Social ☐Episodic abuse ☐Loss of control ☐Use in spite of adverse consequences
☐Recovering
Types of substance(s):_____
Frequency: _____ Amount: _____
Family member(s) abuse? ☐yes ☐no
If yes, who: _____

LEGAL HISTORY

Have you ever been arrested? ☐yes ☐no
If yes, for what reason and age: _____
_____

SOCIAL HISTORY

With whom do you discuss difficult problems? ☐Family ☐Friends ☐Others_____

What do you do for pleasure and relaxation? _____

_____

MEDICAL HISTORY

Check all that apply

Type of Problem	During Childhood	Past as an adult	Currently
Allergies/asthma			
Heart problems			
Epilepsy or seizures			
High blood pressure			
Serious head injury			
Injury resulting in loss of consciousness			
Lead poisoning			
Broken bones			
Surgery			
Migraine headaches			
Thyroid condition			
Problems with vision			
Problems with hearing			
Diabetes			

Any other serious medical problems (explain): _____

_____

Please list current medications:

Name of medication	Dose/frequency	Length of time on medication

Are you presently under a physician's care for physical problems? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Have you ever experienced infertility? ☐ Yes ☐ No

If yes, describe infertility treatment and outcome: _____

_____

PSYCHIATRIC HISTORY OF SELF AND FAMILY

Family history (child, siblings, birthparents, uncles/aunts, cousins, grandparents) for any of the following
Check all that apply

	Self		Family Member Relationship to Client
	Past	Current	
Learning difficulties			
ADHD/ADD			
Depression/suicide (specify)			
Bipolar Disorder/Manic Dep.			
Anxiety difficulties			
Nervous breakdown/Schizophrenia			
Sleep disorders			
Eating Disorders			
Abuse (sexual, physical, neglect)			
Explosive temper			
Other:			

Have you or any other family member ever been involved in therapy? ☐ Yes ☐ No

If yes, when: _____ Issues Addressed: _____

_____

_____

_____

Are you in treatment with another mental health provider at the current time? ☐ Yes ☐ No

If yes, provide names and telephone numbers: _____

_____

_____

If necessary, would other family members be willing to attend therapy sessions? ☐ Yes ☐ No

If no, please indicate reason: _____

_____