Adult Background Questionnaire (v.6.5.05)
Behavioral Medicine Associates of MidMichigan, P.C.

Instructions: This questionnaire covers several problems that may or may not apply to you. Some of the questions may be difficult to answer. Please read each question carefully and choose an answer which *best describes your current situation most of the time*. Write N/A if the question does not apply to you. Please feel free write extra remarks in the margins or on a separate sheet of paper if it will clarify your answers.

Name _____ Date _____

Complete address _____

Home phone _____ Work phone _____ Cell phone _____

Date of birth _____ Sex _____ Marital status _____ No. of marriages _____

Occupation _____

Who referred you to us? _____

Name/phone# of family doctor _____

Name/phone# of psychiatrist _____

Name/phone# of current/prior therapist _____

Years of education for yourself_____, spouse_____ , father_____, mother_____

In the space below, list the first names and ages of all your children:

In the space below, list the first names and ages of all your siblings:

In the space below, list the jobs you have held and the length of time you were at each:

What are your present career goals?

What are your current living arrangements?

Describe your current religious affiliation: _____

Describe the religious affiliation of your family of origin: _____

Describe your ethnicity or cultural background: _____

Describe your physical health: _____

List any medical problems in the space below:

What medications are you currently taking?

What herbal supplements or nontraditional remedies are you using?

Please indicate on the scale below the extent to which your problems interfere with the following:

	Never	Rarely	Sometimes	Often	Always
Work/School	1	2	3	4	5
Daily activities	1	2	3	4	5
Thoughts	1	2	3	4	5
Feelings about self	1	2	3	4	5
Relationships	1	2	3	4	5

Has there ever been a time when your feelings about yourself or your social life changed significantly as a result of gaining or losing a good deal of weight? If yes, please explain a little bit in the space below:

How much do you currently exercise?

Were there any particular events in your life, either positive or negative, which you feel are associated with the start of your problem? Check as many of the following as necessary or add others in the space provided:

Death of a significant other _____
Illness/injury to self _____
Teasing about appearance _____
Failure at school or work _____
Difficult sexual experience _____
Illness/injury to significant other _____
Problems with romantic relationship _____
Family problems _____
Leaving home _____
Marriage _____
Pregnancy _____
Work transition _____
Loss of a friend _____
Other (please describe below)

In the space below, describe any past psychological treatment you have had (include what type, when, where, and whether or not it was helpful).

Does anyone else know about your problem? If yes, how do you know they know?

If female, have you noticed any relationship between your problem and your menstrual cycle?

Have you noticed any relationship between your problem and the time of the year?

What type and how many alcoholic drinks have you had in the last week? _____

Have you ever had a drug or alcohol problem? (circle one choice below)

Extreme Very much Moderate Slight Not at all

If so, did your present problems start before, after, or at the same time as the drug or alcohol problem?

In the space below, please list any close relatives that have ever had a drug or alcohol problem:

About how many cups of coffee/tea do you drink each day?_____

About how many cans of "pop" do you drink each day? _____

About how many cigarettes, cigars, pipes do you smoke each day? _____

Have you ever attempted suicide? If so, please describe what happened in the space below:

Have you ever purposely tried to hurt or injure yourself? Is so, please describe below:

Have you ever had trouble controlling how you spend money? If so, please describe below:

Have you ever engaged in sexual intercourse? _____ How old were you the first time? _____

How satisfied are you with your current level of sexual activity? (circle one choice below)

Extremely Very Satisfied Somewhat Not at all

Have you ever been abused in any way? If so, please describe in the space below:

Indicate how frequently you have the following symptoms by circling numbers on the scale below:

	Never	Rarely	Sometimes	Often	Always
Depression	1	2	3	4	5
Anxiety	1	2	3	4	5
Getting up/morning	1	2	3	4	5
Falling asleep	1	2	3	4	5
Staying asleep	1	2	3	4	5
Crying episodes	1	2	3	4	5
Irritability	1	2	3	4	5
Fatigue	1	2	3	4	5
Dizziness	1	2	3	4	5
Can't concentrate	1	2	3	4	5
Nightmares	1	2	3	4	5
Feelings of panic	1	2	3	4	5
Rapid mood changes	1	2	3	4	5
Feeling that others are talking about you	1	2	3	4	5

Indicate the quality of your relationships with the following individuals:

	Terrible	Poor	Fair	Good	Excellent
Mother	1	2	3	4	5
Father	1	2	3	4	5
Husband/wife	1	2	3	4	5
Boyfriend/girlfriend	1	2	3	4	5
Male children	1	2	3	4	5
Female children	1	2	3	4	5
Boss/teachers	1	2	3	4	5
Male friends	1	2	3	4	5
Female friends	1	2	3	4	5

In the space below, please describe in detail 1) what your present difficulties are, 2) how long they have existed, and 3) your reasons for seeking treatment at this time. Please continue your answer on the back of this page if necessary.