

# BACKGROUND INFORMATION FORM

## Adult

**Instructions:** To help us offer you the highest quality service, please fill out this form as fully and openly as possible. All of the information here is held in the **strictest confidence** within legal limits. To make this process easier for you, we offer checklists wherever possible.

### **Basic Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### **Relationship Status:**

\_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Separated/Divorced \_\_\_\_ Widowed \_\_\_\_ Remarried \_\_\_\_ Partnered

### **Ethnic Origin:**

\_\_\_\_ African American \_\_\_\_ Asian \_\_\_\_ Caucasian \_\_\_\_ Hispanic \_\_\_\_ Native American \_\_\_\_ Other

### **Religion:**

\_\_\_\_ Catholic \_\_\_\_ Christian \_\_\_\_ Jewish \_\_\_\_ Lutheran \_\_\_\_ Mormon \_\_\_\_ Islamic \_\_\_\_ No Religion \_\_\_\_ Other

### **Primary Care Clinic:**

CentraCare  St. Cloud Medical Group  Williams Integracare  Health Partners  Other \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Psychiatric Provider: \_\_\_\_\_

### **Current Family Information:**

- 1) If you are currently married or partnered, how long have you been married/partnered? (\_\_\_\_\_ years).
- 2) If so, what is your spouse's/partner's name? \_\_\_\_\_ his/her age \_\_\_\_\_.
- 3) If you are separated, divorced or widowed, how long has that been? (\_\_\_\_\_ years).
- 4) How many times have you been married? (\_\_\_\_\_ times)
- 5) If you have children, please complete the following (use backside of page, if you need more room):

Child's Name	Age	Child lives with me.		If "no" who does she/he live with and where?
		Yes	No	
1.				
2.				
3.				
4.				
5.				

Any miscarriages or stillbirths? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_

Besides any children and/or spouse listed above, *who else lives in your home?*

Person's Name	Age	Relationship to You

**Areas of Concern:** Please check from the following list, the main areas of concern you would like to address in therapy.

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anxious Feelings                  | <input type="checkbox"/> Feeling Depressed    | <input type="checkbox"/> Relationship Difficulties     | <input type="checkbox"/> Drug Problems        |
| <input type="checkbox"/> Problems Adjusting                | <input type="checkbox"/> Work/Career Concerns | <input type="checkbox"/> Difficulties with School      | <input type="checkbox"/> Attention Difficulty |
| <input type="checkbox"/> Anger Issues                      | <input type="checkbox"/> Alcohol Problems     | <input type="checkbox"/> Memory Problems               | <input type="checkbox"/> Eating Disorder      |
| <input type="checkbox"/> Chronic Pain                      | <input type="checkbox"/> Grief & Loss         | <input type="checkbox"/> Sleep Difficulties            | <input type="checkbox"/> Sexual Issues        |
| <input type="checkbox"/> Suicide Thoughts                  | <input type="checkbox"/> Recovery from Abuse  | <input type="checkbox"/> Traumatic Incident            | <input type="checkbox"/> Stress Overload      |
| <input type="checkbox"/> Financial Distress                | <input type="checkbox"/> Panic Attacks        | <input type="checkbox"/> Obsessive Compulsive Problems | <input type="checkbox"/> Bipolar Disorder     |
| <input type="checkbox"/> Problem Behaviors, specify: _____ |   |  |   |
| <input type="checkbox"/> Other Issues: _____               |   |  |   |

Overall, how much difficulty do these issues cause you in the following areas of life?

(0 = none, 1 = mild, 2 = mild/moderate, 3 = moderate, 4 = moderate/severe, 5 = severe)

- |                             |                 |                            |                   |
|-----------------------------|-----------------|----------------------------|-------------------|
| _____ Work                  | _____ Finances  | _____ Leisure              | _____ School      |
| _____ Parenting             | _____ Self-care | _____ Primary Relationship | _____ Social Life |
| _____ Other, specify: _____ |                 |                            |                   |

For your main area(s) of concern, please name the concern and answer the questions related to that issue. If you want to mention more than one area of concern, the next page offers space to describe them.

**Area of Concern:** \_\_\_\_\_

- 1) When did this problem begin?  Just recently  This month  This year  Last year  2 yrs. ago  
 3-5 yrs ago  6-10 yrs ago  Over 10 yrs.  Don't know
- 2) How often do you experience the difficulty?  Multiple times per day  Daily  Multiple times per week  
 Weekly  Monthly  Periodically  Can't say
- 3) How severe is the difficulty?  Mild  Mild/moderate  Moderate  Moderate/severe  Severe
- 4) Is the area of concern:  Getting better  Getting worse  Staying the same
- 5) Where do you experience the problem?  Work  School  Home  Social setting  Crowds  Everywhere
- 6) What helps relieve the difficulty? (check all that apply).  Exercise  Family  Friends  Leisure  Rest  
 Medication  Meditation/prayer  Psychotherapy  Self help  Close relationship  Sleep  
 Support group  Work  Other \_\_\_\_\_
- 7) What adds to the difficulty: (check all that apply).  Family  Friends  Primary relationship  Finances  
 Grief/loss  Parenting  Work  Other \_\_\_\_\_

**Area of Concern:** \_\_\_\_\_

- 1) When did this problem begin?     Just recently     This month     This year     Last year     2 yrs. ago  
 3-5 yrs ago     6-10 yrs ago     Over 10 yrs.     Don't know
- 2) How often do you experience the difficulty?     Multiple times per day     Daily     Multiple times per week  
 Weekly     Monthly     Periodically     Can't say
- 3) How severe is the difficulty?     Mild     Mild/moderate     Moderate     Moderate/severe     Severe
- 4) Is the area of concern:     Getting better     Getting worse     Staying the same
- 5) Where do you experience the problem?     Work     School     Home     Social setting     Crowds     Everywhere
- 6) What helps relieve the difficulty? (check all that apply).     Exercise     Family     Friends     Leisure     Rest  
 Medication     Meditation/prayer     Psychotherapy     Self help     Close relationship     Sleep  
 Support group     Work     Other \_\_\_\_\_
- 7) What adds to the difficulty: (check all that apply).     Family     Friends     Primary relationship     Finances  
 Grief/loss     Parenting     Work     Other \_\_\_\_\_

**Area of Concern:** \_\_\_\_\_

- 1) When did this problem begin?     Just recently     This month     This year     Last year     2 yrs. ago  
 3-5 yrs ago     6-10 yrs ago     Over 10 yrs.     Don't know
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 Medication     Meditation/prayer     Psychotherapy     Self help     Close relationship     Sleep  
 Support group     Work     Other \_\_\_\_\_
- 7) What adds to the difficulty: (check all that apply).     Family     Friends     Primary relationship     Finances  
 Grief/loss     Parenting     Work     Other \_\_\_\_\_

**Symptoms:** The following is a list of questions about things you may be experiencing.

**Mood:**

**Part I**

1. Do you have a history of depression or are you currently feeling depressed?  Yes  No
2. If yes, does your depression come and go?  Yes  No  
If **yes**, how many times has it done so? \_\_\_\_\_  
If **no**, has it been there continuously most of your life?  Yes  No
3. How old were you when you were first depressed? \_\_\_\_\_
4. Does the depression get worse in the winter?  Yes  No
5. If you are **female**, is your depression (or anxiety/irritability) worse **before your periods**?  Yes  No
6. If you are **female**, are you going through your change of life (**menopause**)?  Yes  No  
If **yes**, has your depression gotten worse in the midst of this change?  Yes  No

Please check the symptoms of depression that you are **currently** experiencing

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Depressed mood          | <input type="checkbox"/> Hopeless feeling     | <input type="checkbox"/> Trouble sleeping               |
| <input type="checkbox"/> Sleeping too much       | <input type="checkbox"/> Poor concentration   | <input type="checkbox"/> Memory impaired                |
| <input type="checkbox"/> Little or no energy     | <input type="checkbox"/> Low motivation       | <input type="checkbox"/> Irritability                   |
| <input type="checkbox"/> Loss of appetite        | <input type="checkbox"/> Eating too much      | <input type="checkbox"/> Recent weight loss             |
| <input type="checkbox"/> Moving slowly           | <input type="checkbox"/> Hard to enjoy things | <input type="checkbox"/> Feeling agitated or stirred-up |
| <input type="checkbox"/> Feeling worthless       | <input type="checkbox"/> Excessive guilt      | <input type="checkbox"/> Thoughts of wanting to die     |
| <input type="checkbox"/> Withdrawing from others |   |   |

**Part II**

1. Have you ever had thoughts of ending your life?  Yes  No  
If **yes**, have you attempted to take your life?  Yes  No  
If **yes**, how many times? \_\_\_\_\_  
If **yes**, please list what you attempted to do and when: \_\_\_\_\_  
\_\_\_\_\_
2. If you've had suicidal thoughts, but haven't attempted, what has stopped you? \_\_\_\_\_  
\_\_\_\_\_
3. Do you have suicidal thoughts now?  Yes  No

**Part III**

1. Has there ever been a period of time when you were not your usual self and... (check all that apply)

<input type="checkbox"/> Felt extremely good or hyper	<input type="checkbox"/> Had trouble concentrating
<input type="checkbox"/> Shouted at people or started arguments	<input type="checkbox"/> Had much more energy
<input type="checkbox"/> Felt incredibly self-confident	<input type="checkbox"/> Were much more active or did more things
<input type="checkbox"/> Got much less sleep and didn't miss it	<input type="checkbox"/> Were much more social or outgoing
<input type="checkbox"/> Couldn't slow your mind down	<input type="checkbox"/> Spent more money than you could afford
<input type="checkbox"/> Did things others thought were excessive, foolish or risky	<input type="checkbox"/> Talking more loudly or faster than usual
<input type="checkbox"/> Felt sudden changes in mood	<input type="checkbox"/> Felt driven to do fun things
<input type="checkbox"/> Had trouble sitting still	<input type="checkbox"/> Felt more irritable and angry
<input type="checkbox"/> Hard time getting to sleep	

## **Anxiety:**

### **Part I**

1. Have you had a sudden attack of intense fear or discomfort that included: (Check all that apply)
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Pounding/racing heart           | <input type="checkbox"/> Chest pain/discomfort            | <input type="checkbox"/> Feel like you are dying |
| <input type="checkbox"/> Sweating                        | <input type="checkbox"/> Sick to your stomach             | <input type="checkbox"/> Numbness or tingling    |
| <input type="checkbox"/> Trembling/shaking               | <input type="checkbox"/> Feeling like things are not real | <input type="checkbox"/> Feeling of choking      |
| <input type="checkbox"/> Feel like you're losing control | <input type="checkbox"/> Lightheadedness                  | <input type="checkbox"/> Chills                  |
| <input type="checkbox"/> Trouble breathing               | <input type="checkbox"/> Feeling like you're not real     |  |
2. Do you avoid going places because you are worried you may have an anxiety attack?  Yes  No
3. Do you have to force yourself to go places that you would prefer to avoid because of this worry?  Yes  No

### **Part II**

Please check all of the following that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Frequent nervousness or anxiousness  | <input type="checkbox"/> Feeling restless or keyed up                 |
| <input type="checkbox"/> Frequent worry about a number of things  | <input type="checkbox"/> Fearful about going out and about            |
| <input type="checkbox"/> Anxious or uncomfortable about being in a social setting                                       | <input type="checkbox"/> Headaches                                    |
| <input type="checkbox"/> Muscle tension /pain   | <input type="checkbox"/> Trouble Sleeping                             |
| <input type="checkbox"/> Upset stomach  | <input type="checkbox"/> Thoughts going round and round               |
| <input type="checkbox"/> Pictures in your mind that play over and over  | <input type="checkbox"/> Feeling driven to check things over and over |
| <input type="checkbox"/> Being especially afraid of certain things, what specifically? _____                            |   |
| <input type="checkbox"/> Feeling driven to do certain things over and over to feel less nervous? What especially: _____ |   |
- 

### **Part III**

1. Have you ever been sexually or physically abused or assaulted, or been the victim of another violent crime?  Yes  No
- 2) Have you ever witnessed someone else being sexually or physically abused?  Yes  No
- 3) Have you ever been in an accident, fire, or natural disaster where you or someone else was seriously injured or killed?  Yes  No

If you answered **yes** to one of the above, please check all of the following that apply:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Sudden memories of the event            | <input type="checkbox"/> Upsetting memories of the event             | <input type="checkbox"/> Nightmares                            |
| <input type="checkbox"/> Feeling physical reactions to reminders | <input type="checkbox"/> Feeling distress about reminders            | <input type="checkbox"/> Avoiding activities related to event  |
| <input type="checkbox"/> Avoiding places related to event        | <input type="checkbox"/> Avoiding thoughts and feelings              | <input type="checkbox"/> Loss of interest in life's activities |
| <input type="checkbox"/> Detached or numb feeling                | <input type="checkbox"/> ability to recall details of the experience | <input type="checkbox"/> Sense of limited future               |
| <input type="checkbox"/> Difficulty falling or staying asleep    | <input type="checkbox"/> Irritability or outburst of anger           | <input type="checkbox"/> Difficulty concentrating              |
| <input type="checkbox"/> Being overly alert to danger            | <input type="checkbox"/> Feeling jumpy or easily startled            | <input type="checkbox"/> Having difficulties in relationship   |

### **Situational Stresses:**

- 1) Are there any recent or current situational stresses in your life that are causing significant difficulty?  Yes  No  
If so, please name: \_\_\_\_\_
- 2) In reaction to this/these situation(s) are you experiencing any of the following? (check all that apply).
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Feeling overwhelmed                        | <input type="checkbox"/> Feeling anxious                     | <input type="checkbox"/> Feeling depressed                     |
| <input type="checkbox"/> Having trouble deciding                    | <input type="checkbox"/> Having trouble coping               | <input type="checkbox"/> Having trouble managing your feelings |
| <input type="checkbox"/> Behaving in ways that are not good for you | <input type="checkbox"/> Having difficulties in relationship |  |

### **Attention/Concentration/Memory:**

1. Do you have difficulty paying attention and concentrating at work school, or home?  Yes  No
2. Is it hard for you to sit still for more than ½ hour at a time?  Yes  No  
If **yes**, have you had these problems since you were a child?  Yes  No
3. Have you ever been diagnosed with Attention Deficit/Hyperactivity Disorder?  Yes  No  
If **yes**, were you treated with medication?  Yes  No  
If **yes**, What medicines? \_\_\_\_\_
4. Do you have trouble with your memory?  Yes  No  
If **yes**, please explain \_\_\_\_\_  
If **yes**, how long have you had trouble? \_\_\_\_\_

### **Perception and Beliefs:**

1. Do you hear things other don't hear (auditory hallucinations)?  Yes  No
2. Do you see things other don't see (visual hallucinations)?  Yes  No
3. Do you believe that others are spying on you or are out to get you?  Yes  No
4. Do you think that others are talking about you?  Yes  No
5. Do you think that someone is putting thoughts into your head?  Yes  No
6. Do you believe you have special powers?  Yes  No
7. Do you think that you receive special messages through the TV or radio?  Yes  No

### **Substance Use:**

1. Do you drink alcohol?  Yes  No  
If **yes**, how often? \_\_\_\_\_  
If **yes**, approximately how much each time? \_\_\_\_\_  
If **no**, have you drank alcohol in the past?  Yes  No
2. Do you use street drugs?  Yes  No  
If **yes**, what kind? \_\_\_\_\_  
If **yes**, how often? \_\_\_\_\_  
If **no**, have you used street drugs in the past?  Yes  No
3. Have you ever misused prescription medications? (e.g. pain pills or anxiety pills)  Yes  No
4. Have alcohol or drugs caused any problems for you in the past or present?  Yes  No  
If **yes**, what kind of problems? \_\_\_\_\_
5. Have you ever been in chemical dependency treatment?  Yes  No  
If **yes**, when? \_\_\_\_\_

### **CAGE Questions:**

1. In the last three months, have you felt you should cut down or stop drinking *or using drugs*?  Yes  No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking *or using drugs*?  Yes  No
3. In the last three months, have you felt guilty or bad about how much you drink *or use drugs*?  Yes  No
4. In the last three months, have you been waking up wanting to have an alcoholic drink *or use drugs*?  Yes  No

**Other Concerns:**

1. Are you comfortable with your current body weight?  Yes  No
2. Do you or have your ever tried to lose weight by eating very little or fasting?  Yes  No
3. Have you ever used laxatives, diuretics, or made yourself throw up in order to lose weight?  Yes  No
4. Are there times when you eat unusually large amounts of food at one time?  Yes  No
5. Do you experience outbursts of anger?  Yes  No
6. If so, how often: \_\_\_\_ daily \_\_\_\_ Weekly \_\_\_\_ Monthly \_\_\_\_ Occasionally
7. At times, do you yell, shout or name call?  Yes  No
8. Have you ever been physically violent?  Yes  No
9. Do you gamble?  Yes  No
10. If so, how often? \_\_\_\_ daily \_\_\_\_ Weekly \_\_\_\_ Monthly \_\_\_\_ Occasionally
11. Have you ever lost more money than you could comfortably afford?  Yes  No
12. Are you happy/comfortable with your sex life?  Yes  No
13. Any difficulties with sexual performance?  Yes  No
14. Do you use pornography?  Yes  No
15. Do you engage in any sexual behavior that concerns you?  Yes  No

**Medical Conditions:** (Use backside of page if you need more room).

1. Please list any medical conditions for which you are being treated and the approximate date you were diagnosed (even if you can only say within a year or two).

Condition(s)	Date of Diagnosis

2. Please list all current medication(s), dosage and approximate time you started on the medication.

Medication	Dosage	Purpose	Approx. time started

3. Please list any allergies, type of reactions you have (e.g. rash, nausea, trouble breathing), the level of severity of you reactions (mild, moderate or severe) and the approximate time the allergy started.

Allergy	Type of Reaction	Severity	Approx. Date of Onset

4. Please indicate any seasonal allergies and the time of year you have them. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Previous Mental Health Care Received:** Please indicate below what the **treatment** was for (e.g. depression, anxiety, etc.), the **approximate date** the treatment started (It's ok to estimate), the name of the treatment **facility or provider**, the **type of care** you received (e.g. individual therapy, family /couples therapy, hospitalization, etc.) the **outcome** of treatment (poor, fair, good, excellent, etc.) and **how long** treatment lasted.

Treatment For:	Date	Facility/Provider	Type of Care	Outcome	Duration

**Current Life Situation:** In the following areas of life, please check all that apply (it's ok to check more than one option in each category). Feel free to add comments as well.

- Family Life:  Close  Conflicted  Supportive  N/A  Other  
Comments: \_\_\_\_\_
- Primary Relationship:  Close  Conflicted  Supportive  N/A  Other  
Comments: \_\_\_\_\_
- Circle of Friends:  Many  Few  None  Supportive  Draining  Changeable  Other  
Comments: \_\_\_\_\_
- Work Setting:  Challenging  Stressful  Supportive  Rewarding  Unhealthy  N/A  Other  
Comments: \_\_\_\_\_
- Please list hobbies and leisure activities you enjoy: \_\_\_\_\_
- Anything else you would like to add about your current life situation: \_\_\_\_\_

**Social/Developmental History:**

**Education:**

- Years of schooling (0 to 16+) \_\_\_\_\_
- Diploma or highest degree received: \_\_\_\_\_
- Any history of learning difficulties:  Yes  No
- If so, please check all areas of difficulty you have experienced in the area of learning.  Concentration  Hearing  Listening  Reading  Writing  Remembering  Other Comments: \_\_\_\_\_

**Employment:**

1. Are you currently employed?  Yes  No
2. If yes, where? \_\_\_\_\_
3. What is your job title? \_\_\_\_\_
4. If not employed, are you (check all that apply)  Actively looking for work  Disabled  Terminated  
 Choosing not to be employed  Laid-off  Needing Childcare  Attending school  Retired  Other
5. Any history of difficulties with employment?  Yes  No, If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Living Arrangements:**

1. Please describe your current living situation, (e.g. own home, rent an apartment, living with friends/family, retirement community, group home, homeless in a shelter, etc.) \_\_\_\_\_  
\_\_\_\_\_
2. Are you satisfied with your living situation?  Yes  No
3. If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Military Service:**

1. Have you served in the military?  Yes  No
2. If yes, when? From \_\_\_\_\_ To \_\_\_\_\_
3. What branch of service? \_\_\_\_\_
4. How would you describe the experience?  Mostly positive  Mostly negative  Positive & Negative  Neutral
5. Please explain: \_\_\_\_\_  
\_\_\_\_\_

**Legal Issues:**

1. Are you currently involved in any legal difficulties (facing charges, involved in a lawsuit, on probation)  Yes  No  
**If yes, briefly describe your difficulties:** \_\_\_\_\_  
\_\_\_\_\_
2. Have you had any other legal problems in the past?  Yes  No  
**If yes, please briefly describe your difficulties** \_\_\_\_\_  
\_\_\_\_\_

**Family History:**

1. Please list the member(s) in your **family of origin**. Include parents, step-parents, siblings, and step-siblings. Indicate approximate age (or if deceased, approximate year of death), relationship to you (mother, father, sister brother, stepmother, stepfather, stepbrother, stepsister, etc.) and relationship with you (check all that apply).

Name of Family Member	Age or (yr. of death)	Relationship to you	Relationship with you (check all that apply)
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other
			<input type="checkbox"/> Healthy <input type="checkbox"/> Loving <input type="checkbox"/> Supportive <input type="checkbox"/> Neutral <input type="checkbox"/> Distant <input type="checkbox"/> Conflicted <input type="checkbox"/> Abusive <input type="checkbox"/> Other

2. Were your parents ever separated or divorced?  Yes    No, If yes, how old were you when that occurred? \_\_\_\_\_
3. Describe the relationship between your mother and father (check all that apply).    Healthy    Loving  
 Supportive    Neutral    Distant    Conflicted    Abusive    Other
- Comments: \_\_\_\_\_

**Family Psychiatric History:** Think of your biological relatives: mother, father, sister, brother, son, daughter, maternal grandparents, paternal grandparents, aunt, uncle, niece, nephew or cousin. Have any of them been treated for any of the following conditions?

For each **condition**, list the **relative(s)** who had the condition, the **treatment** they received (none, out-patient, in-patient or if you don't know), the **outcome** of the treatment (poor, fair good, excellent, etc.) and the **approximate year** of the treatment (it's ok to estimate).

Condition	Relatives	Treatment	Outcome	Approx. year
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Depression				

Anxiety				

Alcohol Issues				

Drug Abuse				

Suicide Attempts				

Bi-Polar Disorder				

Psychosis				

Other (name)				