PERSONAL BACKGROUND FORM

Name (of client this form refers to): ________________________________

1. Check all that apply:
   - □ Single
   - □ Married
   - □ Divorced
   - □ Widowed
   - □ Living with intimate partner

2. Living Arrangements. Currently living with (check all that apply):
   - □ Roommate
   - □ Significant other/romantic partner
   - □ Parents
   - □ Siblings
   - □ Other (please specify: ________________________________)

3. FAMILY INFORMATION

<table>
<thead>
<tr>
<th>Spouse/Partner</th>
<th>Name</th>
<th>Age</th>
<th>Living w You?</th>
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Children (Please list all children whether living with you or not)

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<th>(1) Name</th>
<th>Age</th>
<th>Living w You?</th>
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4. Ethnic/Racial Background:
   - □ Asian/ Pacific Islander
   - □ African-American/ Black
   - □ Caucasian
   - □ Hispanic/ Latino
   - □ Other (please specify) ________________________________

5. What is your religious affiliation? ________________________________

   Is your religious background important to you/affect your life? ________________________________

6. Do you have any cultural backgrounds that are important to you? If yes, please give a brief description:

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

7. Are you currently employed? □ Yes, full-time □ Yes, part-time □ No, currently unemployed

   If yes, what type of work do you do? ________________________________

8. Please estimate your yearly gross income (not including spouse’s income): $_____________________

9. Please estimate your family’s yearly gross income: $_____________________

10. Please indicate the number of adults & children living on above income: ___ adults ___ children
11. How many years of schooling have you completed?
- □ Less than 8th grade
- □ Completed 8th grade
- □ Some high school
- □ Graduated high school or equivalence
- □ Completed 8th grade
- □ Some college
- □ Graduated college with degree in _____________
- □ Some post-graduate degree training in ___________
- □ Graduated high school or equivalence
- □ Post-graduate degree in ________________

12. Are you currently in school? □ Yes □ No

   If yes, what are you studying?: ________________________________________________________________

13. Have you had a physical examination within the last six months? □ Yes □ No

   If yes, what were the results?: ________________________________________________________________

14. Are you currently receiving medical care? □ Yes □ No

   If yes, please describe briefly:
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

15. Name of physician in case of emergency: __________________________ Phone: ______________________

16. Have you experienced any of the following health problems? Please check all that apply:
- □ High blood pressure/Hypertension
- □ Cardiac/Heart problems
- □ Cancer
- □ Diabetes
- □ Respiratory problems
- □ Chronic pain
- □ Stroke
- □ Headaches
- □ Thyroid Issues
- □ Ulcer or other gastrointestinal problem
- □ Kidney disorder
- □ Chronic or frequent headaches
- □ Dizziness
- □ Fainting or Blackouts
- □ Seizures/Convulsions
- □ Memory problems
- □ Asthma
- □ Any other health problems? ________________________________________________________________

17. Have you been hospitalized for illness or injury in the past 10 years? □ Yes □ No

   If yes, approximate dates and condition: _______________________________________________________

18. Have you been hospitalized for a psychiatric/psychological reason? □ Yes □ No

   If yes, approximate dates and issue: _____________________________________________________________

19. Are you currently taking any medications?

   Type of Medication                  Average Dosage                  Frequency
   _____________________________                  _____________                  _____________
   _____________________________                  _____________                  _____________
   _____________________________                  _____________                  _____________


20. Have there been any serious illnesses, accidents, deaths or other physical concerns within your family in the past 5 years?  □ Yes  □ No
   If yes, please specify: __________________________________________________________
   ____________________________________________________________________________

21. Have you ever had any personal (individual) psychotherapy?  □ Yes  □ No
   If yes, for what concern? ______________________________________________________
   Approximate date: _______________  For how long? ________________________________

22. Have you ever had couple counseling or family therapy?  □ Yes  □ No
   If yes, for what concern? ______________________________________________________
   Approximate date: _______________  For how long? ________________________________

23. If you have received therapy before, was it helpful?  □ Yes  □ No
   If yes, in what way was it helpful? _____________________________________________
   If not, in what way was it unsatisfactory? ________________________________________

24. Please provide the following information about your family:
   Mother: Name: ________________________________________________________________
            If deceased, year and cause of death:______________________________
            If living, age and health status:______________________________
            If living, where does she live now?__________________________
            Her occupation (past and/or present)__________________________
   Father: Name: ________________________________________________________________
            If deceased, year and cause of death:______________________________
            If living, age and health status:______________________________
            If living, where does he live now?__________________________
            His occupation (past and/or present)__________________________
   Other guardians/parental figures (e.g., step-parent, partner of parent, aunt):
            Name(s): ______________________________________________________
            If deceased(s), year and cause of death:__________________________
            If living, age and health status:______________________________
            If living, where does (s)he live now?__________________________
            His/her occupation (past and/or present)________________________
   Siblings:
            __________________________________________  ______        __________
            Name  Age                Occupation  Where located?
            __________________________________________  ______        __________
            Name  Age                Occupation  Where located?
            __________________________________________  ______        __________
            Name  Age                 Occupation  Where located?
            __________________________________________  ______        __________

25. Where did you grow up? ______________________________________________________
26. Where your parents ever separated?  □ Yes  □ No  If yes, when? ________________________________

27. In your own words, what brings you into the clinic? ____________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

28. Have you had problems like this before?  □ Yes  □ No  If yes, when? ________________________________

29. Have you ever used any drugs or medications other than as prescribed?  This includes prescription medications, marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, opiates, Ecstasy, and others.  □ Yes  □ No

Are you currently using any of these drugs?  □ Yes  □ No

If yes, please fill out the requested information:

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<th>Type</th>
<th>Frequency/Amount</th>
<th>Duration</th>
<th>How taken</th>
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30. Do you drink alcohol?  □ Yes  □ No

If yes, how much do you drink? _______ drinks per ________

If yes, do you feel your drinking has caused any problems in your work, school, or relationships?  □ Yes  □ No  Please explain: ____________________________________________
__________________________________________________________________________________________

31. Have you experienced any particular sources of stress in the last year?  □ Yes  □ No

If yes, please explain: ____________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

32. Are there any other health care professionals (e.g., physicians, psychotherapists, social workers, etc.) whom you feel might have information that would help in treatment?  □ Yes  □ No

If yes, please give details: ____________________________________________
__________________________________________________________________________________________

33. Is there any other background information you think would be helpful to know?  □ Yes  □ No

If yes, please explain: ____________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________