Center for Disability Services
Where people get better at life

CENTER HEALTH CARE

Psychology / Social Work & Psychiatry Background Questionnaire

The information in this form is very important. Please fill out as completely as possible and return to our office prior to your first appointment to: **Center Health Care, Behavioral Health, 314 South Manning Blvd., Albany, NY 12208 or fax to: (518) 437-5554.** Please supply us with any relevant reports including Psychological, Psychiatric and Psycho-Social reports.

NOTE: "Patient" refers to the person receiving services. **Today's Date: ______ / ______ / ______**

Patient Name	Form completed by: Indicate relationship to patient; leave blank if same as patient:
Address _______________________________	Home Phone ( ) ____________ Cell Phone ( ) ____________ Work Phone ( ) ____________
Date of Birth ______ / ______ / ______	Race: Religion or spiritual practice:
Primary Language Spoken: ☐ English ☐ Spanish ☐ Other	Other Language(s) Spoken
Referred by:	Referral Phone ( )

Describe the reason for referral, including questions and concerns:

FAMILY DATA

Parent: MOTHER	**Parent: FATHER**
Name	Name
DOB ______ / ______ / ______ Date of Death ______ / ______ / ______	DOB ______ / ______ / ______ Date of Death ______ / ______ / ______
Address	Address
Phone ( )	Phone ( )
Occupation	Occupation
Marital Status ☐ Married ☐ Divorce ☐ Widowed ☐ Never Married ☐ Separated ☐ Living with Partner	Marital Status ☐ Married ☐ Divorce ☐ Widowed ☐ Never Married ☐ Separated ☐ Living with Partner
Schooling completed:	Schooling completed:
Educational difficulties:	Educational difficulties:
Psychological difficulties:	Psychological difficulties:
Does patient have contact with mother? ☐ Yes ☐ No	Does patient have contact with father? ☐ Yes ☐ No
☐ Check if patient has a **Legal Guardian**; if checked, write in individual's name: _______________________________ Please provide proof of guardianship to Enrollment Office for adults; bring proof of custody for children if there are custody issues.	☐ Check if patient has a **Legal Guardian**; if checked, write in individual's name: _______________________________ Please provide proof of guardianship to Enrollment Office for adults; bring proof of custody for children if there are custody issues.

Patient's Siblings

Name	DOB	Address	Contact with Patient (how often)

Patient's Spouse / Partner

CURRENT: ☐ Husband ☐ Wife ☐ Partner	**FORMER:** ☐ Husband ☐ Wife ☐ Partner
Name	Name
Address	Address
Phone	Phone
Occupation	Occupation
Marital Status ☐ Married ☐ Divorce ☐ Widowed ☐ Never Married ☐ Separated ☐ Re-Married ☐ Living with Partner	Marital Status ☐ Married ☐ Divorce ☐ Widowed ☐ Never Married ☐ Separated ☐ Re-Married ☐ Living with Partner
School Completed:	School Completed:
Educational Difficulties:	Educational Difficulties:

Patient's Children

Name	DOB	Address	School or Job

Who lives in the patient's home?

Patient's Developmental History

History During Pregnancy

At time of patient's birth	**Mother's Age** _____ **Father's Age** _____
Length of term	☐ Premature ☐ Full Term ☐ Post-mature (late)
Maternal illness or accidents during the pregnancy:	
Maternal medications during the pregnancy:	
Parental alcoholic beverages consumed during pregnancy?	**Mother** ☐ Yes ☐ No **Father** ☐ Yes ☐ No
If yes to above, indicate type of alcohol, amount & frequency	**Mother** Type_____ Amount_____ Frequency_____ **Father** Type_____ Amount_____ Frequency_____
Parental drug use:	**Mother** ☐ Yes ☐ No **Father** ☐ Yes ☐ No
Type of drug(s), amount & frequency.	**Mother** Type_____ Amount_____ Frequency_____ **Father** Type_____ Amount_____ Frequency_____
During pregnancy, did parents smoke (nicotine)?	**Mother** ☐ Yes ☐ No **Father** ☐ Yes ☐ No
If yes, how many cigarettes each day?	**Mother** _____ per day **Father:** _____ per day

Patient's Developmental History *(continued)*

Birth History

Birth Weight:	
Complications of delivery?	☐ No ☐ Yes If yes, explain:
Any birth defects?	☐ No ☐ Yes If yes, explain:
Condition after birth (color, etc):	
Was neonatal intensive care needed?	☐ No ☐ Yes If yes, length ___________ Explain:
Did baby go home with the mother from the hospital?	☐ No ☐ Yes
Length of stay in the hospital for the:	Mother ____________ Baby ____________
Were there any feeding problems?	☐ No ☐ Yes If yes, please describe:
Were there any sleeping problems?	☐ No ☐ Yes If yes, please describe:
In infancy, was there:	☐ Diarrhea ☐ Colic ☐ Anemia ☐ Reflux ☐ Hypotonia ☐ Cerebral Palsy ☐ Respiratory Problems ☐ Seizures

Indicate items that were true for the baby in the first year of life: (Please check ✓ all that apply)

☐ Easy to manage	☐ Irregular in sleeping / feeding	☐ Fussy
☐ Happy	☐ Fearful of new people / situations	☐ Slow to warm-up in new situations
☐ Adaptable to new situations	☐ Intense in reactions	☐ Inactive
☐ Regular in sleeping / feeding	☐ Smiled	☐ Not easily upset
☐ Nervous	☐ Difficult to comfort	☐ Liked to be held
☐ Alert	☐ Other	☐ Made eye contact

Were there any special problems in the growth and development as a child during the first few years?

☐ No ☐ Yes If yes, explain (eg, any speech, motor delays, extremes of temperament, separation anxiety, separations from parents) ____________________

____

Milestones: At what AGE did patient:

Sit without support	Begin putting words together
Crawl	Spoke in sentences
Walk unassisted	Toilet train – Day
Speak first word	Toilet train – Night

Did you or your doctor have any concerns about the child's development? (walking, talking, movement, eating, etc)
If yes, explain: ____________________

____

Did the child have a developmental evaluation? If yes, please supply a copy to our office. ☐ No ☐ Yes

By Whom? ____________________

Has there been a diagnosis of Fetal Alcohol Affect or Syndrome? ☐ No ☐ Yes

By Whom? ____________________

Patient's Educational History

Did patient attend day care?	☐ Yes ☐ No	If yes, at what age:	How long:
Did patient attend preschool?	☐ Yes ☐ No	If yes, at what age:	How long:
Age of entering kindergarten?			
Has patient repeated any grades? ☐ Yes ☐ No	If yes, indicate the grades and give the reasons for retention: Grades: ______________________ Reasons: ______________________		

Schools Attended

Name & Location	Grades	Dates	Reason for Leaving

Has the patient received any of the following special school services?

Service	Yes	No	Locations / Grades / Ages
Reading			
Math			
Speech / Language Services			
Occupational Therapy			
Physical Therapy			
Counseling in school			
Social Skills Group in school			
Special Education services			
Psychological Evaluation *(bring to appointment)*			
Behavior Therapy / Modification *(bring Behavior Intervention Plan, if current)*			

☐ Self-Contained ☐ Resource Room ☐ Consultant Teacher ☐ Individual Aide ☐ Shared Aide

What is your impression of patient's learning ability?

Patient's Work History *(if applicable)*

Occupation / Position	Location	Start / Finish	Reason for Leaving

Patient's Residential History

Current Residence:

Length of time at this residence:

Previous Residence **(1)**:

Length of time at this residence:

Previous Residence **(2)**:

Length of time at this residence:

Patient's Drug / Alcohol / Legal History

What is the patient's current use of alcohol? Type: Frequency:

What is the patient's current use of drugs? Type: Frequency:

Any past use of alcohol? ☐ Yes ☐ No Length of use: Frequency:

Any past use of drugs? ☐ Yes ☐ No Length of use: Frequency:

If yes, please list:

Treatment received for drug or alcohol use (ie, Detox, Rehab, Outpatient)?

Does the patient smoke: ☐ Yes ☐ No Treatment received:

Has the patient ever been in trouble with the law? ☐ Yes ☐ No If yes, please describe:

Social History

Has the patient or any of the patient's family experienced the following? Please give a simple explanation.

Problem	**Response**	**Who**	Describe problem
Drinking	☐ Yes ☐ No		
Drug use	☐ Yes ☐ No		
Fighting	☐ Yes ☐ No		
Hitting	☐ Yes ☐ No		
Yelling	☐ Yes ☐ No		
Name calling	☐ Yes ☐ No		
Threatening	☐ Yes ☐ No		
Arguing	☐ Yes ☐ No		
Sexual abuse	☐ Yes ☐ No		
Physical abuse	☐ Yes ☐ No		
Arrested	☐ Yes ☐ No		
Jail / Prison	☐ Yes ☐ No		
Separation	☐ Yes ☐ No		
Divorce	☐ Yes ☐ No		
Job changes	☐ Yes ☐ No		
Loss of income	☐ Yes ☐ No		
Hospital stay	☐ Yes ☐ No		
Suicide	☐ Yes ☐ No		
Serious illness or injury	☐ Yes ☐ No		
Military history	☐ Yes ☐ No		
Contact with Child Protective	☐ Yes ☐ No		
Contact with Adult Protective	☐ Yes ☐ No		
Placement outside the home	☐ Yes ☐ No		
Been in court	☐ Yes ☐ No		
Case management	☐ Yes ☐ No		
Other agencies	☐ Yes ☐ No		
Family problems	☐ Yes ☐ No		
Other problems	☐ Yes ☐ No		
Significant deaths	☐ Yes ☐ No		

Patient's Medical History

Please check ✓next to any illness or conditions the patient has had. If an item is checked, also note the approximate date (or age) of the illness.

Check ✓	Illness / Condition	Dates / Ages	Check ✓	Illness / Condition	Dates / Ages
	Measles			Dizziness	
	Whooping Cough			Extreme Tiredness	
	Mumps			Cancer	
	Chicken Pox			Anemia	
	Pneumonia			Respiratory Infections	
	Broken Bones			Jaundice / Hepatitis	
	Ear Infections			High Blood Pressure	
	Asthma			Gonorrhea / Syphilis	
	Epilepsy / Seizures			Blood Disorders	
	Exposure to lead			Diabetes	
	Inattention			Miscarriages	
	Hyperactivity			Fainting Spells	
	Impulsivity			Head Injury	
	Environmental Allergies			Stroke	
	Bedwetting			Paralysis	
	Vision Problems			Memory Problems	
	Hearing Problems			Frequent Headaches	
	Tics / Tourette's			Difficulty Concentrating	
	Eating Problems			Anxiety	
	Sleeping Problems			Depression	
	Fever above 104°			Suicide attempt	
	Heart Disease			Drug Allergies	
	Other:			Adverse Drug Reactions	

Psychiatric Hospitalizations / Residential Placements / Foster Care / Respite

Date of Placement	Placement Site or Type	Reason / Explanation

Other Hospitalizations

Date of Stay	Hospital	Reason

Primary Care Doctor: ____

Address: ______________________________ City ____________________ State ______ Zip ______

Office Phone: ( ) ____________________ Fax #: ( ) ____________________

Date of last physical: ______ / ______ / ______

Results: ____

Current Medications (OR Write NONE)

Medication (OR Write NONE)	Dosage Per Administration	Time of Administration	Problems, if any

Currently taking over-the-counter herbal remedies: ☐ Yes ☐ No If yes, list them:

Past Psychotropic Medications (OR Write NONE)

Past Psychotropic Medication (OR Write NONE)	Reason For and Date of Discontinuation (if known)

Medication Allergies or Adverse Drug Reactions (OR Write NONE)

Medication Allergies or Adverse Drug Reactions (OR Write NONE)	List any allergies that required an emergency medical visit or special treatment

Family Medical History

Check ✓	Illness / Condition	Relationship to Patient	Check ✓	Illness / Condition	Relationship to Patient
	Alcoholism			Tics or Tourette's	
	Substance Abuse			Required Special Ed.	
	Cancer			Depression	
	Diabetes			Bipolar Disorder	
	Heart Disease			Attention Disorder	
	Autism/Autism Spectrum			Other (Describe):	
	Developmental Delays including or Intellectual Disabilities and Autism Spectrum Disorders – **Describe:**				

Patient's Mental Health History

Has the patient ever had an evaluation with a Psychiatric Practitioner for consideration of psychotropic medication? ☐ Yes ☐ No

Practitioner Name	Practitioner Phone
Address	City, State, Zip

What was the result?

If patient or family is currently seeking **psychiatric medication management**, please describe briefly why.

Previous Psychological Evaluations: ☐ Yes ☐ No If yes, please supply copies to our office or bring to your first appointment.

What other agencies is the patient or family involved with?

Counseling History

Name of Counselor / Agency	Year	Reason for Counseling	Effectiveness of Counseling

Additional Information:

What are the patient's **favorite** activities?

1. ______________________________
2. ______________________________
3. ______________________________

What are the patient's **least** favorite activities?

1. ____
2. ____
3. ____

Have there been any unusual experiences or events in home or history which you find would help the service provider understand the patient?

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Additional Information that you feel is important:

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If you have not already supplied our office with the following, please do so as soon as possible:

- Previous Psychological Testing
- IEP / ICP
- Behavior Support or Intervention Plans with recent data, if available
- Summary Records from previous Mental Health Practitioners
- Proof of Guardianship
- Proof of Custody (if Shared Custody)

All this is needed to provide you or your family with the best service we can.

Please fill out as completely as possible and return to our office prior to your first appointment to:
Center Health Care, Behavioral Health, 314 South Manning Blvd., Albany, NY 12208
OR Fax to: (518) 437-5554