DR. CESTNICK

ADULT BACKGROUND QUESTIONNAIRE

Your name: ____ Today's date: _______________________________

Birth date: ___________________________ Age: ___________Sex (circle one): Male Female

Home address: ___________________________________City: ___________________________Zip Code: ____________

Phone: Home # ______________________ Cell #_________________________ Other # ________________________

Email: _____________________________________ School (if student):____

Job/employer (if employed): ____

Physician(s): ____

Address of Physician(s): ____

Phone of Physician(s): ____

Education: ____ Marital status: _______________________________________

List all people and pets living in household:

Name	Relationship to You	Age

Primary language: ____

Other languages: ____

REASON FOR REFERRAL

Briefly describe your presenting problems/difficulties: ____

____

____

How long has this problem been a concern for you? _ ____

When was the problem first noticed?: ____

What seems to help the problem?: ____

What seems to make the problem worse?: ____

Have you received evaluation or treatment for the current problem or similar problems? Yes _______ No _______

If YES, what type(s) of evaluation(s), when, and by whom: ____

____

____

What are your strengths? ____

____

____

What are your hobbies?

____

____

____

Who referred you Dr. Cestnick?: ____

DEVELOPMENTAL HISTORY (this requires consulting parents if living; not dire but very helpful)

CIRCLE/CHECK appropriate answers below:

During pregnancy, was mother on medication? YES / NO If yes, what kind? ______________________________________

During pregnancy, did mother smoke? YES / NO If yes, how many cigarettes each day? _

During pregnancy, did mother drink alcoholic beverages? YES / NO If yes, what did she drink? ___________________________

Approximately how much alcohol was consumed each day? ____

During pregnancy, did mother use drugs? YES / NO If yes, what kind? ____

Were forceps used during delivery? YES / NO

Was a Cesarean section performed? YES / NO If yes, for what reason? ____________________

Carried to term? YES / NO ______ If no, at what prenatal age were you born?

What was your birth weight? ______________________

Were there any birth defects or complications? Yes ______ No ______ If yes, please describe: __________________

Were there any feeding problems? Yes _______ No ______ If yes, please describe: _______________ ____________

Were there any sleeping problems? Yes ______ No ______ If yes, please describe: ______________________________

As an infant, were you quiet? Yes ______ No ______

As an infant, did you like to be held? Yes ______ No ______

As an infant, were you alert? Yes ______ No ______

Were there any special problems in growth and development during the first few years? Yes ____ No____

If yes, please describe: ____

The following is a list of infant and preschool behaviors. Please indicate the age at which you first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to mother	______	Put several words together	______
Rolled over	______	Dressed self	______
Sat alone	______	Became toilet trained	______
Crawled	______	Stayed dry at night	______
Walked alone	______	Fed self	______
Babbled	______	Rode tricycle	______
Spoke first word	______		

MEDICAL HISTORY

Are you on any medication at this time? YES / NO

If yes, please note types, amounts, and duration of taking varied medications: ____

____

____

Allergies: ____

Place a check next to any illness or condition that you have had. When you check an item, also note the approximate date (or age) of the illness.

Check	Illness or condition	Date(s) or age (s)	Check	Illness or condition	Date(s) or Age(s)
_____	Measles	____________	_____	Dizziness	____________
_____	German measles	____________	_____	Frequent/severe headaches	____________
_____	Mumps	____________	_____	Difficulty concentrating	____________
_____	Chicken Pox	____________	_____	Memory problems	____________
_____	Whooping cough	____________	_____	Extreme tiredness or	
_____	Diphtheria	____________	_____	weakness	____________
_____	Scarlet fever	____________	_____	Rheumatic fever	____________
_____	Meningitis	____________	_____	Epilepsy	____________
_____	Encephalitis	____________	_____	Tuberculosis	____________
_____	High fever	____________	_____	Bone or joint disease	____________
_____	Convulsions	____________	_____	Gonorrhea or syphilis	____________
_____	Allergy	____________	_____	Anemia	____________
_____	Hay fever	____________	_____	Jaundice/hepatitis	____________
_____	Injuries to head	____________	_____	Diabetes	____________
_____	Broken bones	____________	_____	Cancer	____________
_____	Hospitalizations	____________	_____	High blood pressure	____________
_____	Operations	____________	_____	Heart disease	____________
_____	Ear problems (disease, infection, injury or impaired		_____	Asthma	____________
_____	hearing)	____________	_____	Sexual problems	____________
_____	Tubes for ears when young	________________	_____	Bleeding problems	____________
_____	Visual problems	____________	_____	Eczema or hives	____________
_____	Fainting spells	____________	_____	Suicide attempt	____________
_____	Loss of consciousness	____________	_____	Menstrual problems	____________
_____	Paralysis	____________	_____	Numbness or tingling	____________

SOCIAL, EMOTIONAL AND BEHAVIORAL HISTORY

CIRCLE/CHECK areas that are or were of concern – write a "C" for current or "P" for past beside the cirlce

Attention	Hyperactivity	Clumsy
Impulsivity	Blank spells	Daredevil
Give up easily	Slow to learn	Easily frustrated
Shy/timid	Relationship problems	Stubborn
Over/under eating	Reading	Nightmares
Coordination	Speech Perception	Aggression toward self or others
Nervousness	Hearing	Sleeping (explain): _____________
Articulation	Fears (explain): ______________	Vision
Memory	Crying spells/sadness	Self-esteem
Sexual drive/performance	Job satisfaction	Legal problems (explain): ____________________
Social skills (explain):	Relationship problems:	Nail biting or other nervous habits:
_________________________	__________________________	(explain) _____________________
_________________________	__________________________	___________________________

Any prior diagnoses (list here)? ____

Any counseling/psychotherapy now or in past? YES / NO (circle one)

If YES, please state reason for counseling/psychotherapy ____________________________________

____

____

____

Duration of therapy, with whom, and was it effective?

____

____

Are you happy with your friendships (number of, quality of, level of intimacy)?

____

____

Any notable problems with peers or colleagues?

____

____

____

Any physical, emotional or sexual abuse? Please explain:

____

____

____

What are your favorite activities?

____

____

____

What activities would you like to engage in more than at present?

____

____

____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of your family has had. When you check an item, please note the relationship to you and whether from your maternal (mother) or paternal (father) or step/adoptive family lines. Step/adoptive should be elaborated upon if notable contact with those families lending to potential impact upon you.

Check	Condition	Relationship to you	Check	Condition	Relationship to you
_____	Alcoholism	__________	_____	Depression	
_____	Cancer		_____	Learning disability	
_____	Diabetes		_____	ADHD	
_____	Heart trouble		_____	Mental Retardation	
_____	Bipolar Disorder		_____	Anxiety Disorder	
			_____	Other	

____

____

____

____

EDUCATIONAL HISTORY

CIRCLE/CHECK academic areas of concern:

Reading Spelling Vocabulary Writing Math Oral Expression

Did you ever utilize special education classes in grade or high school? YES / NO

If yes, what type of class? ____

Were you ever held back a grade? YES / NO

If yes, what grade and what led to that?____

Any social or behavioral concerns? YES / NO If yes, explain: ______________________________

____

Did you receive tutoring or therapy in school? YES / NO

Were you ever on an IEP or 504 (circle which)? YES / NO If yes, for how long? ____________________

Please describe IEP or 504 accommodations ____

____

____

____

OTHER INFORMATION

Have you ever been in trouble with the law? YES / NO (circle one) If YES, Explain ____________________

____

____

Please use this space for any additional information that would be helpful for me to know when working with your child. Thank you.

____

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____

Name: ______________________________ Date: ___________________________

Signature: ______________________________