Dr. Nancy Goldov
PSYD, LP, BC-DMT

# BACKGROUND QUESTIONNAIRE

This questionnaire is intended to help me get an understanding of your experiences and situation so that I can better help you receive the best possible treatment. Feel free to leave blank any questions which do not apply or which you prefer not to answer in this format. I'll follow-up with you on many of these items.

Your Name: _____ Today's Date: _____

Please summarize your reason for seeking services at this time:

_____

_____

_____

_____

_____

_____

_____

When did you first begin to experience or notice the above concerns you're seeking help for?

_____

On a scale of 1 to 10, where 1 is the least amount of concern/distress you have ever experienced and 10 is the absolute highest amount of concern/distress you have ever experienced, what number would you say you have been at for the last few days? _____

*Educational/Military Background:*

What is the highest school degree you have earned? _____

During school, did you receive any of the following:
Special education? _____ Evaluation for a learning disability? _____

Tutoring? _____ Alternative schooling? _____ Disciplinary actions? _____

Have you ever served in the military? Y N If yes, please answer the following:
Dates of service: _____ Type of discharge: _____

Combat experience? Y N Highest rank: _____

*Work/Vocational History:*

What is your current occupation? _____

Employer? _____

How long have you been employed in your present position? _____

Are you satisfied with your current job? Y N

Since becoming an adult, how many different jobs have you held? _____

Have you had any periods of unemployment which lasted four months or longer? Y N

If yes, please briefly describe circumstances: _____

Have you made any career changes? Y N

If yes, previous occupation(s)? _____

Any major changes in your current work situation during the past year? Y N

If yes, please describe: _____

Have you relocated or changed jobs in the past 24 months? Y N

*Medical History:*

Please list any medical conditions you have and the type of treatment you are receiving for each.

_____

_____

_____

_____

Please list all medications you are currently taking, including dosages if you know them.

| Medication & Dosage | Prescribed by | Reason prescribed |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list all "over the counter" medications, sleep aids, vitamins, minerals, herbs, and/or dietary supplements you are currently using.

| Agent & Dosage | Condition/Problem |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Have you ever had a major surgery? Y N Have you ever fainted or had a seizure? Y N

Have you ever had a head injury which resulted in loss of consciousness or which may have been associated with a concussion or with problems in thinking, emotion, or behavior? Y N

Have you ever had an extremely high fever (greater than 103° F)? Y N

Do you have any medication allergies or sensitivities? Y N

If yes, please specify: _____

Do you have any food or seasonal allergies or sensitivities? Y N

If yes, please specify: _____

Do you regularly engage in physical exercise? Y N

If yes, please describe: _____

Please list any other medical conditions or concerns: _____

_____

Do you have a primary care physician? Y N If so, who?: _____

Date of last medical examination: _____

*Prior experience with psychological/psychiatric treatment:*

Have you been in counseling or psychotherapy previously? Y N

If yes, please indicate when and by whom: _____

_____

Have you ever taken medications for psychological/psychiatric reasons? Y N

If yes, please indicate when and for what problems/conditions: _____

_____

_____

Have you ever been hospitalized for psychological/psychiatric reasons? Y N

If yes, please describe: _____

Has anyone in your family (parents, grandparents, siblings, children, or other relatives) been diagnosed and/or treated for psychological/psychiatric condition(s)? Y N

If yes, please describe: _____

*Current and past use of alcohol and other substances:*

If you are currently drinking, please describe the type of alcoholic beverages, the amounts, and the frequency: _____

_____

_____

If you currently drink alcohol, how many days in the past year have you had 4 or more drinks in one day? _____

If you have used, or currently use, any recreational drugs, please describe which ones and your pattern(s) of use: _____

_____

_____

Have you ever tried to cut down on your use of alcohol or drugs? Y N
Has anyone gotten angry at you because of your alcohol or drug use? Y N
Have you ever felt guilty or worried about your use of alcohol or drugs? Y N
Have you ever felt the need for an "eye-opener" in the morning? Y N
Have you ever received outpatient alcohol and/or drug treatment or detoxification services? Y N
Have you ever received inpatient alcohol and/or drug treatment or detoxification services? Y N
Has anyone in your family had a problem with alcohol or drugs? Y N
Please describe your past and current use of nicotine products and/or caffeine:

_____

_____

_____

*Legal Actions/Proceedings:*

Please check all of the following legal actions or proceedings of which you have been a part:

_____ Arrests/assault _____ Arrests/other _____ Divorce/custody
_____ Restraining/protective order(s) _____ Child Protective Services
_____ Disability claim(s) _____ DUI (How many? _____)
_____ Other (describe) _____

*Personal information:*

Place of birth: _____ Where were you raised? _____

Have you experienced a loss (death, divorce, or significant situational loss) in the past 24 months? Y N

Did you experience any losses as above during childhood or adolescence? Y N

If yes, please indicate who and your age at time of loss: _____

Have you relocated or changed jobs in the past 24 months? Y N

How many siblings do you have, and what is your birth order among them? _____

Were you adopted or separated from your birth parents during childhood? Y N

If yes, at what age? _____

Were/are your parents divorced? Y N If yes, your age at the time of separation: _____

Please indicate your parents' current ages or their ages at the time of their deaths:

_____

Mother's occupation(s)/highest level of education: _____

Father's occupation(s)/highest level of education: _____
Has religion or spirituality played an important role in your life? Y N

Has race, ethnicity, or culture played an important role in your life? Y N

Do you own or have access to firearms? Y N

Have you experienced physical, emotional, or sexual trauma or abuse? Y N
If yes, this is something we can talk more about in person.

What are some of the best (most positive) life experiences you have had?
_____

_____

_____

What do you consider to be your strengths or talents?
_____

_____

_____

What are some of the things for which you feel a sense of personal accomplishment/satisfaction?
_____

_____

_____

How have you gotten through times of hardship or stress in the past?
_____

_____

_____

What's going right in your life now? _____

_____

_____

Who, if anyone, can you count on now when you need them? _____

_____

Who, if anyone, really "gets" you and understands how you think or feel or do things?
_____

What is it like when you are in a satisfying relationship (with peers, colleagues, friends, family members, or loved ones)? _____

_____

What are your goals for our working together? _____

_____

Please use the space below to provide any additional information that you think would be important for me to know. _____

_____

_____

Thank you for taking the time to complete this questionnaire.

Your signature: _____

Reviewed by: _____

Nancy Goldov, PsyD, LP, BC-DMT

Updated: 12/15/13