Website: www.mccaskillfamilyservices.com
E-mail: office@mccaskillfamilyservices.com
Fax: 734-416-0158

Plymouth Location:
409 Plymouth Rd., Suite 250, Plymouth, MI 48170
734-416-9098
Brighton Location:
2040 Grand River Annex, Suite 300, Brighton, MI 48114
810-224-1676

ADULT BACKGROUND QUESTIONNAIRE

Name:	**Date of Birth:**	**Age:**	**Gender:**

Home Address:

Date form completed:	**Primary Physician:**

Who referred you to our office?

If necessary, I give McCaskill Family Services permission to call me at the following numbers:

	Phone Number	**Ok to leave message?**	
Home Phone		Yes	No
Work Phone		Yes	No
Cell Phone		Yes	No
Emergency Contact Person: (Include name & relationship to you)		Yes	No

Marital status:

Occupation:	**Place of employment:**
Employment status: Full-time Part-time Unemployed	**Highest grade completed:**

List all people living in your household:

Name	Relationship	Age

Primary language spoken in the home:	Other languages spoken in the home:

Name of person responsible for bill:	SS#

Have your ever been in trouble with the law? Yes or No

If yes, please explain:

Are you involved in any legal issues at this time (i.e., probation, divorce, custody issues, etc.): Yes or No

If yes, please describe briefly:

PRESENTING PROBLEM

Place a check next to any areas that you are currently experiencing difficulties with:

	Communication/speech		Depressed mood
	Coordination		Specific fears or phobias
	Hearing		Tics or repetitive behaviors
	Vision		Rigid/repetitive rituals or routines
	Aggression		Social withdrawal
	Impulsive behavior		Maintaining social/romantic relationships
	Focus/attention		Marital/family conflict
	Excessive energy/activity levels		Conflict with co-workers
	Low energy		Recognition of social cues
	Behavior that is dangerous to self or others		Stress/anxiety
	Excessive video game playing/technology use		Biting nails or other nervous habits
	Employment		Nightmares
	Substance use		Falling asleep
	Eating habits		Sleeping through the night
	Grief		Waking in the morning
	Traumatic event		Other:

Describe your current difficulties (feel free to use back of this form or attach additional pages if needed):

How long has this problem been of concern to you?	
When was the problem first noticed?	
What seems to help the problem?	
What seems to make the problem worse?	

Have you ever participated in a psychoeducational, neuropsychological or other evaluation for learning, emotional, or behavioral concerns? Please list evaluation history below:

Evaluator/Clinic Name	Date(s) of Evaluation	Findings and/or Diagnoses Received

Have you ever participated in psychotherapy for treatment of emotional, behavioral or other mental health concerns? Please list history below:

Therapist/Clinic Name	Dates of Treatment	Findings or Diagnoses Received

Educational History: Please note if you have ever had difficulties in any of the academic/learning areas included in the table below. ***If you have a history of learning disabilities or other diagnoses which have impacted your academic performances, and/or you have received formal or informal services and/or academic accommodations/supports to address learning weaknesses, please also complete the Educational History Form attached the end of this questionnaire.***

Learning Area	Problem area? Yes or No	When was this problem first noticed?
Reading		
Arithmetic		
Spelling		
Handwriting		
Written expression (e.g., grammar, punctuation, organization, clarity, fluency)		
Attitude towards school		
Organization/study habits		
Other:		
Other:		
Other:		

Medical History:

Medical providers:

Current physician:	How long have you been seen by this provider?
Phone #:	Fax #:
Address:	

Past physician:	When were you last seen by this provider?
Phone #:	Fax #:
Address:	

Other (e.g., psychiatrist, specialist):	How long have you been seen by this provider?
Phone #:	Fax #:

Address:

Allergies:

Allergy	Reaction

Current Medications:

Name of Medication	Prescribed by	Date you began this medication	Current dosage & date dosage was prescribed	Previous dosage(s) & date dosage(s) prescribed/taken

Medication History:

Name of Medication	Prescribed by:	Dosage	Date you began this medication.	Date you stopped taking this medication

History of illness/medical conditions:
Place a check next to any illness or condition that you have had. When you check an item, also note the date(s) or age(s) when illness or condition was diagnosed/experienced.

Check	Illness or Condition	Date(s)/Age(s)
	Measles	
	Mumps	
	Chicken Pox	
	Whooping cough	
	Extreme tiredness	
	Weakness	
	Growth delays	
	Diphtheria	
	Scarlet fever	
	Rheumatic fever	
	Meningitis	
	Epilepsy	
	Tuberculosis	
	Bone or joint disease	
	Gonorrhea or syphilis	
	Anemia	
	Jaundice/hepatitis	
	Diabetes	
	Cancer	
	High blood pressure	
	Heart disease	
	Ear problems	

Check	Illness or Condition	Date(s)/Age(s)
	Asthma	
	Bleeding Problems	
	Visual Problems	
	Hearing Problems	
	Frequent/Severe Headaches	
	Dizziness/Fainting	
	Eczema or Hives	
	Suicide attempt	
	Hospitalization related to suicidal thoughts/behaviors	
	Memory problems	
	Paralysis	
	Loss of consciousness	
	Concussion	
	Encephalitis	
	High fever	
	Convulsions/seizures	
	Hay fever	
	Head injuries	
	Broken bones	
	Hospitalizations	
	Operations	
	Other:	

Family Medical History:
Place a check next to any illness or condition that any member of your family has had (or suspected). When you check an item, please note your relationship to the family member.

Check	Condition	Relationship
	Alcoholism	
	Cancer	
	Diabetes	
	Heart trouble	
	Bipolar Disorder	
	Anxiety Disorder	
	Other:	

Check	Condition	Relationship
	Depression	
	Learning Disability Specify type:	
	ADHD	
	Cognitive impairment	
	Developmental delay	
	Autism	
	Other:	

I think it would be helpful for my clinician/therapist to contact the following professionals who also participate or have participated in my care (e.g., physicians, therapists, tutors, etc.).

Professional's Name & Profession	Phone Number	Fax Number	E-mail Address	Mailing Address

****Please see clinician/therapist to sign an authorization form so that he/she may contact the professionals cited above. ****

Please use this space (or attach additional pages) for any other information that would be helpful for us to know when working with you. Thank you.

My signature below indicates that the information contained in this document is true to the best of my knowledge.

Signature: _____ Date: _____

Educational Intervention History Form:

This form is to help document both formal and informal interventions that have helped your child to succeed throughout his/her academic career. This includes interventions such as: at-home tutoring, IEP/504plans, extra support from teachers, therapy, structured homework time at home etc. For your convenience, you will find an attached list of commonly implemented support services that children tend to receive over the course of their academic career. Please be as specific as possible, (we know it's hard to remember!) documenting length and frequency of intervention, wherever possible.

Grade	Formal Intervention	Informal Intervention	Concerns/Comments
Ex: 5th	*-Speech and language therapy through school. Once per week for the whole year.* *-Cognitive behavioral therapy at McCaskill Family services for anxiety. 6 months.*	*-5th grade teacher would always allow Marie to finish her tests during recess, if she was unable to complete them during class time.* *-Started making visual flashcards with parents for big exams.*	*-Had a hard time staying on task and finishing homework* *-Lots of arguing at home between mom and Marie, mostly about school.*
K			
1st			
2nd			
3rd			
4th			
5th			
6th			

7th			
8th			
9th			
10th			
11th			
12th			

Examples of Frequent Formal and Informal Interventions:

504/IEP/Student Accommodation Plan	Services/meetings with school counselor or school social worker
At-home private tutoring	Frequent parent monitoring to help child prioritize/organize (e.g., task list, calendars).
Tutoring through an agency (e.g., Sylvan, Brainspring)	Parent frequently helps child to stay on task during study time
Parent implemented organizational system	Teacher moving student to front of class to help with focus/behavior
Enrollment in study skills class	Individualized "color chart" or behavioral reward system in school
Individual, family or parent psychotherapy	Teacher providing extra time to take tests or complete assignments
Use of assistive technology	Parent/tutor help implement specific, structured study strategies at home
Use of audiobooks	Speech & Language Therapy