



Beacon Psychology Services LLC

Adult Background Information Form

Name: _____ Preferred name: _____

Today's Date: _____

What are your primary concerns/specific questions you would like help with?

When did you first become concerned about these issues?

Have you sought help for these issues previously? If so, please explain when and with whom:

Past marriages or long-term live-in relationships (when, duration, name of partner):

Current relationship status:

- _____ Single, never married
- _____ Single, living with someone (name of person: _____; length of time: _____ years)
- _____ Married (name of person: _____; length of time: _____ years)
- _____ Separated (name of person: _____; when separation began: _____)
- _____ Divorced (year of divorce: _____)
- _____ Widowed (year of widowhood: _____)

Please list all persons presently living in your home:

Name	Gender	Age	Relationship to you

Family history (child, siblings, birthparents, uncles/aunts, cousins, grandparents) for any of the following:

	None	Yes	Relationship to you
Learning difficulties			
ADHD/ADD			
Depression/suicide			
Bipolar Disorder/Manic Depression			
Anxiety difficulties			
Nervous breakdown/Schizophrenia			
Substance Abuse			
Sleep disorders			
Eating Disorders			
Abuse (sexual, physical, neglect)			
Explosive temper			
Legal problems/jail			

Please list your work history for the last five years:

Highest degree earned: _____

Current work (job title): _____ How long?: _____

Previous work (job title): _____ How long?: _____

Why did you leave?: _____

Previous work (job title): _____ How long?: _____

Why did you leave?: _____

Previous work (job title): _____ How long?: _____

Why did you leave?: _____

Names of physicians/doctors you are currently under treatment with:

Primary physician: _____

Name: _____ Seeing for: _____

Name: _____ Seeing for: _____

Name: _____ Seeing for: _____

Please list current medications:

Name of medication	Dose/frequency	When did you start this medication?