JESSICA E. WILSON, PSY.D.

Background Questionnaire

This questionnaire is to help me understand your life experiences so that we can design therapy that fits your needs. Feel free to leave any questions blank which do not apply or which you prefer not to answer in this format.

Your Name:____

Your Legal Name (if different): ___________________________________

Your Date of Birth: _____________

Your E-mail Address: ____

Your Address: ____

Your Phone Number: ____

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?

____

____

PERSONAL IDENTITY:

Gender Identity (check all that apply):

Man ____ Woman ____ Trans Woman/MtF ____ Trans Man/FtM ____

Nonbinary____ Genderqueer____ Trans-Masculine____ Trans-Feminine____

Gender-Nonconforming____ Third Gender____ Pangender____ Bigender____

Intergender____ Omnigender/Polygender____ Androgyne____ Agender ____

Omnigender____ Two-Spirit ____ Gender Fluid ____ Neutrois ____
Another - please explain: ____

Pronouns:
He/Him____ She/Her ____ They/Them ____ Spivak ____ Ze(Zie)/Hir____
Ze(Zie)/Zir)____ Xe/Xem____
Other - please write out:____

Biological Sex:
Male ____ Female____ Intersex - please specify: ____________________________

Sexual Orientation:
Heterosexual/Straight ____ Homosexual/Gay/Lesbian ____ Bisexual ____ Queer____
Asexual ____ Demisexual____ Pansexual ____ Questioning/Unsure ____
Another - please explain (including differing romantic orientation): ________________
____

Are you 'out' with your sexual orientation/gender identity: Yes______ No______

If 'yes' - to whom are you out: ____
____

What is your ethnicity?:____

What is your country of birth?:____

If not U.S., at what age did you immigrate?:__________________________________

EDUCATIONAL/MILITARY BACKGROUND:

What is the highest school degree you have earned? ___________________________

Are you in school now? Yes____ No____

Have you ever served in the military? Yes____ No____

If yes, please answer the following:

Dates of service: _________________________

Type of discharge: _________________________

Combat experience?_________________________

Highest Rank: ______________________________

WORK/VOCATIONAL HISTORY

What is your current occupation?

____

Current Employer:

____

How long have you been employed in your present position?

____

Are you satisfied with your current job? Yes______ No______

Since becoming an adult (18), how many different jobs have you held? _______________

Have you had any periods of unemployment that lasted four months or longer?

Yes______ No______

If yes, please describe circumstances briefly:

____

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

Yes______ No______

If yes, please describe:

____

MEDICAL HISTORY

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

____

____

____

____

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

Medication Dosage

_______________________ _________________________

______________________ ________________________

______________________ ________________________

______________________ ________________________

______________________ ________________________

Please list all HRT hormones or hormone blocking medications you are currently taking:

Medication	Dosage	Method of Administration
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________

Are your hormones prescribed to you by a physician? Yes______ No______

If no, where do you currently receive your hormones from? ____________________________

____

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 major surgery? Yes ______ No______

Describe:____

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?

Yes______ No______

Have you ever had an extremely high fever (greater than 103 F) Yes_____ No_____

Have you ever fainted or had a seizure? Yes_____ No_____

Do you have any medication allergies or sensitivities? Yes_____ No_____

If yes, please specify:

____

Do you have any food/seasonal allergies or sensitivities? Yes_____ No_____

If yes, please specify:

____

Do you regularly engage in physical exercise? Yes_____ No_____

If yes, please describe:

____

Date of last medical examination: ____________________

Name of Physician: ____

Contact #: ______________________________________

Would you like me to contact your doctor to coordinate your treatment with them:

Yes_____ No_____

PRIOR EXPERIENCE WITH PSYCHOLOGICAL TREATMENT

Have you been in counseling or psychotherapy previously? Yes_____ No_____

If yes, please indicate when and by whom: ____________________________________

____

Was your prior counseling/psychotherapy helpful? Yes_____ No_____

If yes, what did you find most helpful: _______________________________________

____

If no, what did you not find helpful: ____

____

Have you ever taken medications for psychiatric reasons? Yes_____ No_____

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

____

Have you ever been hospitalized for psychiatric reasons? Yes_____ No_____

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

If yes, please describe

____

____

CURRENT AND PAST USE OF ALCOHOL AND OTHER SUBSTANCES

If you currently drink alcohol, please describe the type, amounts, and frequency:

____

____

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? Yes_____ No_____

Has anyone gotten angry at you because of your alcohol or drug use? Yes_____ No_____

Have you ever felt worried about your use of alcohol or drugs? Yes_____ No_____

Have you ever received alcohol and/or drug treatment or detoxification services?
Yes_____ No_____

Has anyone in your family had a problem with alcohol or drugs? Yes_____ No_____

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? Yes____ No____

Did you experience any losses as above during childhood or adolescence? Yes____ No____

If yes, please indicate whom, and your age at the time of loss:________________________

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? Yes____ No____

Were/are your parents divorced or separated? Yes____ No____

If yes, please indicate your age at the time of their separation: ________________________

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

____

Parent's occupation(s)/highest level of education:

____

Parent's occupation(s)/highest level of education:

____

Has religion or spirituality played an important role in your life? Yes____ No____

Has race, ethnicity or culture played an important role in your life? Yes____ No____

Do you own or have access to firearms? Yes____ No____

Have you experienced physical, emotional or sexual trauma or abuse? Yes____ No____

If yes, is this something we can talk about more in person? Yes____ No____

Please check current relationship status (check all that apply):

Single_____ Married_____ Civil Union_____ Domestic Partnership _____ Polyamorous_____ Committed Relationship_____ (monogamous___ poly___ open___) Long Distance_____ Separated _____ Divorced_____ Widowed_____
Other: please explain____

Name of significant other(s): __________________________ ______________________

Number of years together?___________

Please describe the quality of your relationship:

Excellent___ Good___ Needs improvement___ Poor___ History of abuse___
Possibly ending relationship___ In process of divorce___

Are you currently experiencing difficulties sexually? Yes____ No____

If yes, please describe

___

___

Do you have children/stepchildren? Yes____ No____

Names & Ages

___

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 that give you 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 right 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?

Please use the space below to provide any additional information that you think would be important for me to know, including your goals for our work together.

Thank you for taking the time to complete this questionnaire.

Signature

Reviewed by:

Jessica E. Wilson, Psy.D.