



ADULT BACKGROUND FORM

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Name \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital Status: \_\_\_\_\_ Age \_\_\_\_\_ SSN# \_\_\_\_\_

Address \_\_\_\_\_

Best phone number to reach you \_\_\_\_\_ (home, cell or work?)

\_\_\_\_\_ (home, cell or work?)

Is it okay for Dr. Davies to leave a message at these numbers? Yes No

Employer \_\_\_\_\_

Typical work hours \_\_\_\_\_

**Primary**

**Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_

\_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Relationship to Insured Member \_\_\_ Self \_\_\_ Spouse \_\_\_ Child/Dependent \_\_\_ Other

Deductible (if applicable) \_\_\_\_\_ Co-pay \_\_\_\_\_

Member's Date of Birth: \_\_\_\_\_

**Secondary**

**Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_

\_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Relationship to Insured Member \_\_\_ Self \_\_\_ Spouse \_\_\_ Child/Dependent \_\_\_ Other



Are you taking any prescription medications?      Yes                  No

Please list current medications being taken, with any psychotropic medications (antidepressants, anti-anxieties, etc.) listed first:

MEDICATION	DOSE	DATE BEGAN	PRESCRIBING PHYSICIAN
/	/	/	/
/	/	/	/
/	/	/	/
/	/	/	/
/	/	/	/
/	/	/	/
/	/	/	/
/	/	/	/
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/	/	/	/
/	/	/	/

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In your own words, what difficulties or problems are bringing you here at this time?

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When are these problems worse? \_\_\_\_\_

When are they better? \_\_\_\_\_

What have you tried to do to deal with these problems so far? \_\_\_\_\_

When did these problems first begin? \_\_\_\_\_

What important changes have happened to you in the past 6 months? \_\_\_\_\_

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BIO-MEDICAL HISTORY

What serious illnesses have you had (or currently have)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What accidents or injuries have you had? \_\_\_\_\_  
\_\_\_\_\_

Do you have any significant aches or pains or other discomforts? \_\_\_\_\_  
\_\_\_\_\_

	FREQUENCY USED	AGE AT FIRST USE	HAS USE EVER BEEN A PROBLEM?
ALCOHOL	/	/	/
MARIJUANA	/	/	/
OTHER DRUGS/	/	/	/
NICOTINE	/	/	/
CAFFEINE	/	/	/

Have you ever received inpatient or outpatient services for substance use issues?  
Yes                      No  
If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SCHOOL HISTORY

What is your highest level of education? \_\_\_\_\_  
Did you have any difficulties learning? \_\_\_\_\_  
\_\_\_\_\_  
Where your grades usually: Above-Average \_\_\_\_\_ Average \_\_\_\_\_ Below Average \_\_\_\_\_

JOB HISTORY

What is your present job position? \_\_\_\_\_  
Employer \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Do you like your current job? Why or Why not? \_\_\_\_\_  
\_\_\_\_\_

How do people on your job treat you? \_\_\_\_\_  
\_\_\_\_\_

List your previous jobs and state how long you worked at each. Also explain why you left each job.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INTIMATE RELATIONSHIPS

How old were you when you started dating? \_\_\_\_\_

How often did you date as a teenager? \_\_\_\_\_

Any problems you've had with dating? \_\_\_\_\_  
\_\_\_\_\_

Are you currently involved in a committed relationship?    Yes                      No  
If yes, are you satisfied with that relationship? (please explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you satisfied with your present sex life? (please explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What kind of problems (if any) have you experienced in your current or past intimate relationships? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your partner know you are seeking services here? If so, is he/she supportive? \_\_\_\_\_

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FAMILY HISTORY

Describe your family of origin (were you raised by your parents, how many siblings do you have, were you well cared for as a child?) \_\_\_\_\_

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List any significant family members you have lost and how you feel you are coping with that loss

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How would you describe your current relationships with your parents and siblings? \_\_\_\_\_

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Describe any history of mental health or substance abuse problems in your family \_\_\_\_\_

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## CURRENT FAMILY

Please list all persons living in your home and indicate if those relationships are troubled:

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Are current family members aware that you have sought services? \_\_\_\_\_

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Are you interested in having sessions with family members? \_\_\_\_\_

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## GENERAL INFORMATION

List the benefits you expect to receive from therapy. Please be as specific as possible

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Do you think you would be helped by: (Check all that apply)

- Learning how to change specific behaviors  
 Learning *why* you do specific behaviors  
 Learning how to cope with stress/problems  
 Talking/venting about your problem  
 Receiving medicine  
 Involving family/partner in treatment  
 Other: \_\_\_\_\_

In a few words, what do you think therapy is all about?

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How long do you think therapy should last?

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What important qualities/personality should a psychologist have in order to provide you with the most effective treatment?

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Please use the space below to add anything you feel is important for Dr. Davies to know.

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