**SYNERGY CO-PARENTING SOLUTIONS, LLC**

# Background Summary

*Please complete the following form. This information will be helpful in our work together.*

1. **Identifying Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **Treatment History:**

Have you had prior treatment for any of these symptoms? (please circle all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anxiety | Depression | Alcohol abuse | Drug abuse | |
| Relationship problems | Anger | Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

How old were you when you first experienced emotional or psychological problems? \_\_\_\_\_\_\_\_\_\_

Do emotional or psychological problems run in your family? No \_\_\_\_\_ Yes \_\_\_\_\_

Relationship Problem Type of Treatment

Have you ever been hospitalized for a psychological problem? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes: How many times? \_\_\_\_\_\_\_\_\_\_ What years? \_\_\_\_\_\_\_\_\_\_

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Have you ever made a suicide attempt? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes: When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Have you made other suicide attempts? No \_\_\_\_\_ Yes \_\_\_\_\_

Please list medications that you have taken for emotional or psychological problems

(e.g., depression, anxiety, attention deficit, etc.):

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | Started (month/year) | Stopped (month/year) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **Personal Habits:**

### How much caffeine do you consume each day?

### Coffee (6 oz. cups) \_\_\_\_\_ Tea (6 oz cups) \_\_\_\_\_ Soda pop (12 oz.cans) \_\_\_\_\_

### Do you smoke cigarettes? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes: How many per day? \_\_\_\_\_

Do you drink beer, wine, or liquor? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, circle how many drinks per week:

1-2 3-6 7-9 10-12 13-15 16-18 19-21 22-24 25 or more

### Do you think you drink too much? No \_\_\_\_ Yes \_\_\_\_

When was the last time that you used recreational drugs (e.g., marijuana, cocaine,

methamphetamine, etc.)? Please circle:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| last  week | last  month | last  year | last  5 years | last  10 years | over  10 years | never |

1. **Relationship History and Status:**

*Please provide the following information about your current household*

|  |  |  |
| --- | --- | --- |
| household Member | Date of Birth | relationship to you |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

### Please circle your marital status: Single Married Separated Divorced Widowed

How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### If you are currently in a relationship, how would you describe it?

### Have you been married before? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes: How many times? \_\_\_\_\_

###### How many children do you have? \_\_\_\_\_

### How would you describe your relationship with your children?

How would you describe your child’s personality, interests, strengths and struggles?

Describe your Child’s extracurricular Activities (Clubs, Teams, Community Service, Tutoring, Education, etc.)

Do you have any close friends? Please describe briefly:

What memories do you have of your childhood?

Father:

Mother:

Siblings:

What kind of relationship do you have with your parents now?

What kind of relationship(s) do you have with your siblings now?

1. **RESIST/REFUSE DYNAMICS**

Describe your child's relationship with the other parent:

What led to the family conflict as it stands now?

Whenever there is conflict in a relationship, each person plays a role. How have you contributed to the conflict and how have your actions impacted your child?

Which of your behaviors may intentionally or unintentionally promote discord between your child and his / her other parent?

What would help resolve the conflict?

What are you willing to do to achieve that?

What are your greatest fears and concerns about the other parent?

On a scale of 1-10, how important is it for your child to have a positive relationship with the other parent?

Name 3 positive qualities in the other parent.

What do you want the other parent to most understand about you and child’s experience in the conflict?

Describe how you think the conflict looks and feels to your child?

How do you think this affects him or her?

What resolution do you want to see happen?

Who (if anyone) is your child close to in the other parent's family?

Who in your extended family is the child close to?

1. **Education and Work History:**

### Did you graduate from high school? No \_\_\_\_\_ Yes \_\_\_\_\_ GED \_\_\_\_\_

If you did not graduate, what is the highest grade that you completed? \_\_\_\_\_

### While attending school, what grades did you typically earn? A B C D F

Please describe any college coursework, special training, or degrees you obtained beyond high school:

Are you currently employed? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes: What is your job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_

### How many jobs have you had in the last ten years? \_\_\_\_\_

1. **Legal History:**

### Are you currently involved in a legal dispute? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please explain:

### Have you ever been arrested? No\_\_\_\_\_ Yes \_\_\_\_\_ If yes, please explain:

#### VIII. Depression & Anxiety Symptoms:

Please indicate your general mood level over the last month by circling a number on the scale below.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 | 65 | 70 | 75 | 80 | 85 | 90 | 95 | 100 |

Suicidal Depressed Average Happy Joyful

Please indicate your general level of anxiety, nervousness or tension over the last month by circling

a number on the scale below.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | | 7 | 8 | 9 | 10 |
| Peaceful | | | | | | Panicky | | | | | |

1. **Other Symptoms:** (circle yes or no)

I have had anxiety attacks that come on me suddenly and unexpectedly. Yes No

I have a strong urge to repeat certain acts over and over. Yes No

## Disturbing thoughts come into my mind that I cannot get rid of. Yes No

I have had peculiar and strange experiences. Yes No

I sometimes have trouble controlling my anger. Yes No

I have had a traumatic event and have distressing memories of the event. Yes No

I periodically injure myself on purpose. Yes No

I am very fearful of certain places, objects, or animals and go out of my way

to avoid them. Yes No

There are weeks that I feel charged with energy and require almost no sleep. Yes No

As a child, I was frequently in trouble for fighting, lying, stealing, or

skipping school. Yes No

I have had an eating disorder. Yes No