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Adult History Form

The Purpose of this questionnaire is to gather information about your history and present situation so that we may provide the most appropriate clinical services. Please answer each question as honestly and accurately as possible. No one will be allowed to see your records without your permission.

Name ____ Date of Birth ____________________Sex: Female Male

This form completed by: _________________________________ Today's Date ____________________

With whom do you reside? ____

Home Address ____
STREET CITY STATE ZIP

Email: ______________________________ Best contact Phone number: _________________________________

Are you? __Single __Married __Separated __Divorced __Widowed __Unmarried

Place of Birth: ____ Ethnicity _________________________________

Are you adopted? Y N Age at Adoption: _________ Handedness: __Right __Left __Both

Religious Preference ________________________________ How often do you attend service __________________

Do you have children?

Name	Age	Sex	Grade	How is school going?

Other people in the household:

Name	Age	Sex	Relationship to Patient

The Problem:

Who referred you for evaluation? ____

For what current problems or symptoms are you seeking help? ____

____

____

____

How long have you had these problems? ____

Have these problems gotten worse over time? Yes _______ No ________

What other types of treatment/evaluations have you had? ____
____
____

Have you had any of the following? (check all that apply)

Neurological Exam __ Spinal Tap __ CT Scan __ CT Scan ___ EEG __ X-rays ___ MRI ___
Evoked Potentials ___ Angiogram __ Myelogram ___ EMG ___ CT ___ Other ________________

If yes, what were the results? ____
____
____
____

Functional Changes (check all that apply)

Physical Functioning:

Weakness/Hemiplegia	___	Coordination	___	Fatigue	___
Headaches	___	Vision (R/L)	___	Hearing (R/L)	___
Somatosensory/Pain	___	Appetite (Wt. Loss/Gain)	___	Sleep	___

Cognitive Functioning:

Orientation	___	Memory	___	Speech	___
Attention	___	Comprehension	___	Organization	___
Planning	___				

Personality/Interpersonal Relationship Changes:

Personality Change	___	Sexual Functioning	___	Conduct/Behavior	___
Insight/Awareness	___	Affect/Mood	___		

Current Functional Status:

Please rate the following as: (D) Dependent (A) Needing Assistance or (I) Independent:

Bathing:	___	Grooming (Hair/Teeth/Shave)	___
Walking (Gait/Balance)	___	Stairs (Number)	___
Eating (Swallowing)	___	Preparing Meals	___
Toileting	___	Incontinence (Bladder/Bowel)	___
Dressing	___	Other/Special Needs	______________________________

Medical History:

Have you ever had any of the following general medical problems:

Ear Infections?	Yes	___	No	___
Slow Weight Gain?	Yes	___	No	___
Allergies?	Yes	___	No	___
Up-to-date Immunizations?	Yes	___	No	___

Please specify any surgeries you have had performed: ____
____
____

Medications:

Who is you primary care physician? ____

Please list all allergies to medications and/or food: ____
____

Please list all current medications and dosages, and who prescribed them for you: __________________________________
____
____

Please list current over-the-counter medications you are taking: ____
____

Please list any relevant previously prescribed medications: ____
____
____

Neurological History:

Have you ever had any of the following neurological problems:

Head injury with loss of consciousness?	Yes	___	No	___	If yes, how long? ______________
Head injury without loss of consciousness?	Yes	___	No	___	
Dazed, Confused, or Disoriented?	Yes	___	No	___	
Heat Exhaustion/Sunstroke?	Yes	___	No	___	
Partial Drowning?	Yes	___	No	___	
Overcome by gases or fumes?	Yes	___	No	___	
Electrical or chemical shock?	Yes	___	No	___	
Fainting or dizzy spells?	Yes	___	No	___	
High fever over 103 degrees?	Yes	___	No	___	If yes, for how long? ___________
Lead or other poisoning?	Yes	___	No	___	

Other: (specify) ____

Social Functioning:

Are you currently employed? Yes ___ No ___

If not, why? ____
____

How well do you form / maintain friendships /relationships with others? ____

Opposite Sex: ____

School/Work Collegues:____

Authority Figures: ____

Family: ____

Any anticipated changes in your support system? ____
____

Family Medical History:

Has you or any of your relatives had any of the following conditions? (Relatives include your biological parents, brothers and sisters, grandparents, aunts, uncles, and cousins.)

Condition	You	Mother	Father	Sibling	Grandparent	Cousin
Hyperactive						
Behavior Problems						
Reading Difficulty						
Writing Difficulty						
Math Difficulty						
Speech Problems						
Slow Development						
Deformities						
Depression						
Anxiety or Panic Attacks						
Bipolar Disorder						
Tic Disorder						
Heavy Drinking						
Drug Abuse						
Overdose						
Mental Retardation						
Cerebral Palsy						
Brain Hemorrhage						
Brain Tumor						
Encephalitis, Meningitis						
Convulsions, Seizures						
Severe Headaches						
Muscular Weakness						
Thyroid Disease						
Heart Disease						
Stroke						
Diabetes						
Anemia						
Rheumatic Fever						
Cancer						
Asthma						
Kidney/Bowel						
Early Deaths/Miscarriages						
Psychosis						
Dementia						

Please specify any other relevant family medical history: ____
____
____
____

Hearing:
Have you ever been diagnosed with a hearing impairment? Yes ___ No ___
If yes, please specify: ____
Have you been prescribed a hearing aid? Yes ___ No ___
If yes, do you wear it regularly? Yes ___ No ___

Vision:
When was your last eye exam? ____
What were the results of that exam? ____
Have you been diagnosed with any visual impairment? Yes ___ No ___
If yes, please specify: ____

Sleep:
Please specify your typical sleep pattern (time to fall asleep, time to rise, amount of sleep per night):
____
____
Do you have any of the following difficulties? (Check all that apply)

Falling asleep	___	Staying asleep	___	Snoring/snorting	___
Unpredictable length of sleep	___	Early riser	___	Very heavy sleeper	___
Nightmares	___	Night terrors	___	Sleep walking	___
Talking in sleep	___	Other: (specify) ______________________________			

Eating:
Do you eat a healthy diet from all four food groups? Yes ___ No ___
Do you have strange eating habits? Yes ___ No ___
Any recent change in your eating habits or appetite? Yes ___ No ___
If yes, please specify: ____
Any recent change in your weight? Yes ___ No ___
If yes, please specify gain or loss and how much over what period of time: ________________________________
____
____

Substance Use:
Does you smoke cigarettes? Yes ___ No ___
Does you drink alcohol? Yes ___ No ___
Does you use illicit substances? Yes ___ No ___
Do you abuse prescription medications? Yes ___ No ___
If yes, please specify: ____

Developmental History:
How many siblings do you have? Biological ____ Adopted ____
Brothers ____ Sisters ____
What is your birth order? ______________
Do you know if your mother's pregnancy was: Uneventful ____ Complicated ____
Do you know if you were born: Full term ____ Premature at ____ weeks' gestation
Delivery: Vaginal ____ Cesarean ____
Birth Weight (pounds and ounces: __________ Breast Fed: Yes ___ No ___
Age of Mother at Delivery: __________ Age of Father at Delivery: __________

Education:

Did you finish High School? __ Yes __ No
Continued Education level: ___ Some College __ Trade Certificate __ Associates Degree __ BA __ MS __ PhD
Overall, how did you perform in school? Good ____ Fair ___ Poor ___ Grades/GPA: __________
What is your child's BEST class? _______________________ WORST class? ___________________________
Did you ever skip a grade? Yes ___ No ___
Did you ever repeat a grade? Yes ___ No ___
Did you ever have special education services? Yes ___ No ___
Have you ever had an individual IQ test? Yes ___ No ___
If yes, What was the name of the test, reason, and results? ____
____

Psychological History:

Have you ever been treated as an outpatient for psychological/emotional problems? Yes ___ No __
If yes, When: ____
Diagnoses: ____
Who treated you: ____
What type of treatment: ____

Does you have, or ever had problems such as:	**Yes**	**No**
Depressed Mood or loss of interest or pleasure?		
Suicidal thoughts or self-harm?		
Irritability, anger, and/or a short temper?		
More self-confidence than normal?		
Racing thoughts?		
Difficulty adhering to a schedule?		
Impulsiveness?		
Excessive anxiety and worry?		
Feeling restless or on edge, fidgety?		
Feeling tired easily?		
Easily distracted or disorganized?		
Bothered by thoughts that won't go away?		
Trouble with neighbors, teachers, law enforcement?		
Repetitive behaviors that you feel driven to perform?		
Having memories of a traumatic event even when you don't want to?		
Having nightmares associated with a traumatic event?		
Having flashbacks of a traumatic event?		
Fear of new people, places, or events?		
Over talkativeness?		
Nervous twitches or tics?		
Hearing voices or seeing things others don't?		
Thoughts that you are being harassed or cheated?		
Thoughts that you have special powers or can read minds?		
Extreme reaction to noise or sudden movement?		
Overly sensitive to temperature, vibrations, feel of certain things like fabrics?		
Many complaints or headaches, stomachaches, or other medical concerns?		

Are you under any particular stress at this time? Yes ___ No ___
If yes, please specify: ____
____
What are your particular strengths? ____
____
What are your hobbies, interests, recreational / leisure activities? _____________________________________
____
Any additional comments or concerns: ____
____
____