ADULT HISTORY FORM

Patient's Full Name _____
Date of Birth _____ Age _____ Sex _____
Person completing this form _____ Relationship to Patient _____
Home Address _____
Street City
_____ Home Phone # (____)_____
State Zip
Cell Phone # (____)_____ Work Phone # (____)_____
Email Address: _____
Source of Referral: Name: _____
Address _____ Phone # (____)_____
What is the primary language spoken at home? _____
What was the first language learned? _____
Is the patient right-handed, left-handed or ambidextrous? _____
Please list the reason for your visit: _____
_____
_____
What are your goals for the evaluation? _____
_____
_____

General Medical History

Name and phone number of primary care physician _____
Name and phone number of specialist _____
Have you ever had any neuroimaging (ie: EEG/MRI/FMRI/CT)? **YES** **NO** If yes, please bring reports.
Do you currently drive? **YES** **NO** If yes, have there been any incidents in the past two years? (ie: confusion/lost/ticket/accident) Please explain: _____
_____
Describe your use of alcohol/tobacco/recreational drugs: _____
_____

Symptom Survey

Please place a mark (X) next to each symptom that applies and note date of onset

Physical Concern – Date of onset

Headaches _____ Dizziness _____
Balance problems _____ Urinary problems _____
Bowel problems _____ Strength problems _____
Motor problems _____
Other physical concerns _____
_____

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Sensory Concern – Date of onset

Numbness _____ Tingling _____
Visual impairment _____ Wear glasses _____
See things that are not there _____ Hearing impairment _____
Wear hearing aids _____ Problems with taste or smell _____
Other sensory concerns _____
_____

Intellectual Concerns

Problem Solving – Date of onset

Difficulty figuring out how to do new things _____
Difficulty figuring out problems that most others can do _____
Difficulty planning ahead _____
Difficulty changing a plan or activity when necessary _____
Difficulty thinking as quickly as needed _____
Difficulty doing things in the right order (sequencing) _____
Other problems solving issues _____
_____

Language and Math Skills – Date of onset

Difficulty finding the right word _____
Slurred speech _____
Difficulty expressing thoughts _____
Difficulty understanding what others say _____
Difficulty understanding when reading _____
Difficulty writing letters or words (not due to a motor problem _____
Difficulty with math (ie: balancing a checkbook, making change) _____
Other language or math problems _____
_____

Nonverbal Skills – Date of onset

Difficulty telling right from left _____
Difficulty drawing or copying _____
Difficulty dressing _____
Difficulty dong things I used to do automatically (ie: brushing teeth) _____
Difficulty finding way around familiar places _____
Difficulty recognizing objects or people _____
Decline in musical abilities _____
Not aware of time _____
Slowed reaction time _____
Other nonverbal problems _____
_____

Awareness and Concentration – Date of onset

Highly distractible _____
Lose my train of thought easily _____
Mind goes blank a lot _____
Difficulty doing more than one thing at a time _____
Easily confused or disoriented _____
Don't feel alert or aware _____
Tasks require more effort or attention _____
Other awareness and concentration problems _____
_____

Memory – Date of onset

Forget where I leave things (ie: keys, purse, ect) _____
Forget names _____
Forget what I should be doing _____
Forget where I am or where I am going _____
Forget recent events _____
Forget appointments _____
Forget events that happened long ago _____
Forget the order of events _____
Forget facts but can remember how to do things _____
Forget faces of people I know _____
More reliant on others to remind me of things _____
More reliant on notes to remember things _____
Other memory problems _____
_____

Mood and Personality – Date of onset

Sadness and depression _____
Anxiety or nervousness _____
Stress _____
Sleep problems _____
Excessive snoring _____
Become angry more easily _____
Euphoria (feeling on top of the world) _____
Much more emotional _____
Feel as if I just don't care anymore _____
Easily frustrated _____
Less inhibited (do things I would not have done before) _____
Difficulty being spontaneous _____
Change in energy level? *(circle one)* **LOSS** **GAIN**
Change in appetite? *(circle one)* **LOSS** **GAIN**
Change in weight? *(circle one)* **LOSS** **GAIN**
Change in sexual interest? _____

Lack of interest in pleasurable activities _____

Mood and Personality – Date of onset (continued)

Increase in irritability _____
Increase in aggression _____
Other changes in mood or personality or how you deal with people _____
_____

Overall, my symptoms have developed: *(circle one)* **SLOWLY** **QUICKLY**
Over the past six months my symptoms have: *(circle one)* **IMPROVED**
STAYED THE SAME
WORSENED

Is there anything you can do (or someone does) that gets the problem to stop or be less intense, less frequent or shorter? _____
_____

What seems to make the problem worse? _____
_____

Please indicate if you have a history of any of the following. If yes, please briefly describe:

YES	**NO**	Head injury _____
YES	**NO**	Hypertension/High Cholesterol _____
YES	**NO**	Heart Disease _____
YES	**NO**	Stroke _____
YES	**NO**	Seizure _____
YES	**NO**	Neurological Disorder (ie Parkinson's Disease) _____
YES	**NO**	Cancer _____
YES	**NO**	Headaches _____
YES	**NO**	Diabetes/Kidney problems _____
YES	**NO**	Surgeries _____
YES	**NO**	Other (ie thyroid problems, menopause, ect) _____

Have others commented to you about changes in your thinking, behavior, personality or mood? If so, who and what have they said? _____
_____

Please list your current medications, including dosage and approximate start date _____
_____

Please list any medical or psychiatric diseases that run in your family _____
_____

How is your mood? _____
Do you have a history of psychiatric illness? _____
Have you ever been treated for a psychiatric problem? If yes, how? _____
_____

Family History

The following questions deal with your biological mother, father, brothers and sisters

Is your mother alive? **YES** **NO** Mother's highest level of education _____
If deceased, what was the cause of her death? _____
Is your father alive? **YES** **NO** Father's highest level of education _____

If deceased, what was the cause of his death? _____

Family History (*continued*)

Please describe any parental or family history of:

Neurological diseases (ie: Parkinson's, Alzheimer's, Multiple Sclerosis): _____

_____

Psychiatric conditions (ie: Depression, Anxiety, Bipolar Illness, Schizophrenia): _____

_____

Other disorders (ie: problems with attention, learning, speech, language, behavior) _____

_____

How many brothers and sisters do you have and what are their ages? _____

_____

Are there any unusual problems (ie: physical, academic, psychological associated with any of your brothers or sisters? If yes, please describe: _____

_____

Developmental History

Were there any problems with your prenatal development or delivery? *(circle one)* **YES NO**

If yes, explain: _____

Was it a full term pregnancy? *(circle one)* **YES NO**

If yes, explain: _____

Did your mother use alcohol or other drugs during the pregnancy? *(circle one)* **YES NO**

If yes, explain: _____

Did your mother smoke cigarettes during the pregnancy? *(circle one)* **YES NO**

If yes, explain: _____

Did you have any developmental delays (ie: walking, talking, sittign up, ect)? *(circle one)* **YES NO**

If yes, explain: _____

Did you have problems getting along with your peers or siblings as a child? *(circle one)* **YES NO**

If yes, explain: _____

Did you have any tempermant or mood difficulties as a child? *(circle one)* **YES NO**

If yes, explain: _____

Did your parents ever consult with a therapist, psychiatrist or school counselor regarding your childhood difficulties? *(circle one)* **YES NO**

If yes, explain: _____

Circle any of the following that applied to you during your childhood:

Night Terrors	Few Friends	Sleep Problems
Anxious/Worried	Nail Biting	Abused
Frequently in Trouble	Sad/Depressed	Irritable
Delinquent	Withdrawn	Troubles Concentrating
Inattentive	Restless	Hyperactive

Developmental History *(continued)*

Health during childhood (list any illnesses/injuries): _____

_____

Health during adolescence (list any illnesses/injuries): _____

_____

List surgical operations and age or occurrence: _____

_____

Did you consume alcohol or illegal drugs as a child/adolescent? _____
Did you violate the law as a child/adolescent? _____
Did you destroy property as a child/adolescent? _____

Marital History

Current marital status: *(circle)* **SINGLE** **MARRIED** **DIVORCED** **SEPERATED**
Spouse's name (if married): _____
Spouse's place of employment: _____ Phone # (____)_____
Previous Marriages (include names, dates of marriage and divorce): _____

_____

Children:

Name: _____ Age: _____ Resides with you? **YES** **NO**
Name: _____ Age: _____ Resides with you? **YES** **NO**
Name: _____ Age: _____ Resides with you? **YES** **NO**
Name: _____ Age: _____ Resides with you? **YES** **NO**
Name: _____ Age: _____ Resides with you? **YES** **NO**
Name: _____ Age: _____ Resides with you? **YES** **NO**

Educational History

Total number of years of education

Check all that apply:

High School Graduate _____ College Graduate _____ Degree: _____
GED (Age) _____ Technical Training _____ Other: _____

Educational Assistance

Check all that apply:

Resource placement _____ Tutoring _____ Remedial classes _____
Repeated grade _____ Started school late_____ Underachiever _____
Disliked school _____ Poor Motivation _____ Learning disabled _____
Other (please explain): _____

What factors detracted from a successful school experience: _____

_____

Best academic areas: _____

Worst academic areas: _____

Educational History *(continued)*

Name of High School in which you attended _____
Year graduated: _____ GPA _____ School records available **YES** **NO**

Name of Trade School in which you attended _____
Year graduated: _____ GPA _____ School records available **YES** **NO**
Specialty areas: _____
Advanced training (Please describe) _____

Name of College/University _____
Year graduated: _____ GPA _____ School records available **YES** **NO**
Major: _____ Minor _____ Graduate work _____
Degree(s) _____
Specialty areas _____
Advanced areas (Please describe) _____

Previous testing _____
IQ Test _____ Date(s) administered _____
Achievement test scores (High School) _____
College testing (ie ACT, PSAT Entrance Exam) _____
Vocational testing _____ Military testing _____
Military service _____
Brach _____ Years of service _____ Highest rank _____
Specialty areas: _____ Honors _____

Social History

Do you have trouble making friends? YES NO
Do you have trouble keeping friends? YES NO
Were you ever severely teased? YES NO
Do you have trouble in your relationships with others? YES NO
If yes, please explain _____
Are you currently involved with a significant other (marriage/dating partner)? YES NO
Do you have problems controlling your temper/anger? YES NO
If yes, please explain _____
Has your driver's license ever been suspended? YES NO
If yes please explain _____
How many speeding/moving violation tickets have you received? _____
Have you ever been arrested for DUI/DWI? YES NO
How many car accidents, regardless of fault, have you been involved? _____
Have you ever been arrested? YES NO
How many times have you moved since completing high school? _____

Employment History

Present Occupation _____ Number of years employed _____
Employer Name _____
Employer Address _____
Supervisor Name _____ Title _____

Previous Employment

Occupation _____ Number of years employed _____
Employer Name _____
Employer Address _____
Supervisor Name _____ Title _____

Occupation _____ Number of years employed _____
Employer Name _____
Employer Address _____
Supervisor Name _____ Title _____

Occupation _____ Number of years employed _____
Employer Name _____
Employer Address _____
Supervisor Name _____ Title _____

Occupation _____ Number of years employed _____
Employer Name _____
Employer Address _____
Supervisor Name _____ Title _____

Have you ever been terminated from a job? **YES** **NO**
When? _____
Reason: _____