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ADULT HISTORY QUESTIONNAIRE

Please fill out this form completely. If there are any questions you don't understand, they can be filled out when the history is reviewed.
The information you provide is confidential and protected by law.

Identifying Information		***Date:***	
Adult's Name		Date of Birth	
Age		Gender	❑ Male ❑ Female
Name of person completing form:			
Relationship to patient:			
Address			
Home phone			
Work phone			
Cell phone/ other phone			
Email address:			
Handedness		❑ Right Handed ❑ Left Handed ❑ Both (explain)	
Highest grade completed:			
Area of study:			
Who referred you for an evaluation?			
Primary Care Physician: Address Phone			
Date of Last Physical:			

What are you hoping to learn from this evaluation?

EARLY HISTORY

1. Were you born:	❑ On-time ❑ Prematurely ❑ Late
2. Birth Weight:	

3. Were there any problems associated with your mother's pregnancy?

❑ Gestational diabetes ❑ Anemia ❑ Preeclampsia
❑ Sexually transmitted disease ❑ Heart disease ❑ Physical trauma
❑ Placenta previa ❑ Toxemia ❑ Depression
❑ Prenatal Alcohol Exposure ❑ Nicotine/Smoking
❑ Prenatal Drug Exposure Specify: _____
❑ Other

4. Were there any problems associated with your birth?

❑ Oxygen deprivation ❑ Unusual birth position
❑ Other:

5. Were there any concerns or complications during/immediately following your birth?

❑ Baby's heart rate dropped ❑ Low Apgar scores ❑ Breech
❑ Born "blue" ❑ Significant Jaundice (bilirubin)
❑ Cord wrapped around neck/Nuchal Cord
❑ Treatment in the NICU – details: _____

6. Rate your developmental progress to the best of your knowledge:

	Early	**Average**	**Late**
Walking	_____	_____ (9-18 mos.)	_____
Language	_____	_____ (12-24 mos.)	_____
Toilet Training	_____	_____ (13-36 mos.)	_____

7. As a child, did you have any of these conditions? (Check all that apply):

❑ Frequent ear infections ❑ Head injury ❑ Speech problems
❑ Clumsiness ❑ Hearing problems ❑ Vision problems
❑ Developmental delay ❑ Hyperactivity ❑ Behavioral Problems
❑ Attention problems ❑ Learning disability ❑ Other:
❑ Seizures ❑ Psychological Problems

8. Languages spoken other than English:

9. What do you consider your main language?

FAMILY HISTORY

Where were you born?	
Where were you raised?	
Until what year?	

How many siblings do you have and what medical/learning conditions have they experienced?

Name	**Male/Female(circle)**	**Age**	**Condition**
_____	M/F	_____	_____
_____	M/F	_____	_____
_____	M/F	_____	_____
_____	M/F	_____	_____
_____	M/F	_____	_____
_____	M/F	_____	_____

Mother's highest level of education:

Mother's profession:

Father's highest level of education:

Father's profession:

Parents' marital status:

Describe any medical or psychological conditions that run in your family (and in what family member:

Do you live alone or with others? (If with others, whom?):

Current marital status:

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Number of children:

EDUCATIONAL HISTORY:

School Level	**Grad Year**	**Location**	**Discipline**
Elementary			
Middle School			
High School			
College			
Graduate			

Other			

Describe your usual performance as a student?	❑ A & B ❑ B & C ❑ C & D ❑ D & F
Please provide any additional helpful comments about your academic performance:	
What was your strongest subject(s)?	
What was your weakest subject(s)?	
Rate your ability in the following (excellent, poor, fair, etc.): Spelling _____ Reading _____ Arithmetic _____	
Did you ever repeat a grade? If yes, what grade(s)? The reason?	
Were you ever in any special class(es) or did you receive special services for learning difficulties?	
Have you ever had an evaluation before today?	

MEDICAL HISTORY

What are your current symptoms?

Emotional Distress:

❑ Depression/Sadness	❑ Anger	❑ Moodiness
❑ Anxiety	❑ Psychotic-Like Symptoms	❑ Suicidal
❑ Homicidal	❑ Other	

Functional Problems:

❑ Poor Hygiene	❑ Academic problems/concerns	❑ Sleep problem
❑ Problems with mobility	❑ Learning Disability	❑ Inadequate energy
❑ Problems with speech	❑ Social Relationships	❑ Memory problems
❑ Recognition of danger	❑ Cognitive problem	
❑ Money management	❑ Appetite problem	❑ Physical pain/injury
❑ Sensory integration/motor processing		

Lab Findings:

Overall, my symptoms have developed:
❑ Slowly ❑ Quickly

Medical illnesses as a child:

Medical illnesses as an adult:

Have you ever suffered an injury to your head?
❑ Yes ❑ No

If yes, when? Year: _____ Your age: _____
Explain the circumstance and any problems you had afterwards:

Please list any medications you are currently taking (over the counter or prescription medication, and the dosage, if known)**:**
1.
2.
3.
4.
5.

Describe your recent mood:

Have you been involved in psychological or psychiatric treatment?
❑ Yes ❑ No
If yes, with whom? _____
When (dates)? _____
Who suggested the treatment? _____
For what were you treated? _____

ALCOHOL INTAKE
_____ Beverages per week/month
_____ % drink to intoxication
Period of heavy drinking
Years: _____
_____ Beverages per week/month
_____ % drink to intoxication

My last drink was:
❑ less than 24 hours ago ❑ 24-48 hours ago ❑ over 48 hours ago

TOBACCO / DRUG INTAKE

Do you have a history of tobacco use? ❑ Yes ❑ No

Type of tobacco used: _____

Number per day: _____

Do you have a history of illicit substance use? ❑ Yes ❑ No

Type(s) of drug used: _____

Frequency of use: _____

SLEEP / APPETITE / SEXUAL INTEREST:

Describe your recent sleep: _____

Insomnia: ❑ Early Phase ❑ Middle Phase ❑ Late Phase

Describe your recent appetite: _____

Recent weight loss / weight gain? _____

Have there been any recent changes in your sexual interest?

_____

DRIVING:

Do you hold a valid driver's license? ❑ Yes ❑ No

Do you currently drive? ❑ Yes ❑ No

Have you been involved in any car accidents? ❑ Yes ❑ No

Explain: _____

_____

OCCUPATIONAL HISTORY

Job title of patient (if working) Year retired:	
School attending (if student) Major:	
How long have you been at your current job?	

Past jobs:

Position	Years
1.	
2.	
3.	
4.	

OTHER INFORMATION:

Activities of Daily Living:

Describe any problems completing normal activities of living:

Outside interests / hobbies:

Military History:

Have you served in the military? ❑ Yes ❑ No

If yes, what branch?_____ Years served: _____

Highest rank earned: _____ Type of discharge: _____