

Date _____
 Name _____

ADULT HISTORY

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Now	Past		Now	Past	
___	___	Suicidal thoughts	___	___	Homicidal thoughts
___	___	Depression/sadness	___	___	Anxiety/nervousness
___	___	Recurrent/intrusive thoughts	___	___	Nightmares
___	___	Difficulty sleeping	___	___	Loss of appetite
___	___	Overeating	___	___	Weight loss
___	___	Weight gain	___	___	Sexual problems
___	___	Visual/auditory hallucinations	___	___	Apathy
___	___	Anorexia/Bulimia	___	___	Explosive anger
___	___	Rapid mood changes	___	___	Euphoria (feel on top of the world)
___	___	Decreased need for sleep	___	___	Racing thoughts
___	___	Distractible	___	___	Feeling worthless
___	___	Fatigue	___	___	Loss of interest in almost all activities
___	___	Poor self esteem	___	___	Feelings of hopelessness
___	___	Overwhelming need to perform certain behaviors/rituals	___	___	Recurrent/intrusive disturbing recollections or dreams
___	___	Significant concerns with physical problems	___	___	Excessive fears or phobias
			___	___	Other problems:

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
___	___	Death of spouse	___	___	Death of family member	___	___	Illness of family member
___	___	Illness of friend	___	___	Personal injury/illness	___	___	Marital difficulties
___	___	Marital separation	___	___	Divorce	___	___	Sexual difficulties
___	___	Conflicts with family	___	___	Conflicts with friends	___	___	Conflicts at work
___	___	New job	___	___	Job termination	___	___	Retirement
___	___	Business difficulties	___	___	Academic difficulties	___	___	Financial problems
___	___	Change in residence	___	___	Legal problems	___	___	Sexual assault
___	___	Incest/sexual abuse	___	___	Physical abuse	___	___	Verbal/emotional abuse
___	___	Other problems:						

Are you currently receiving therapy? _____ From who? _____
 When did you start therapy? _____ For what problem(s)? _____

List current psychiatric medications: _____
 Have you received therapy in the past? _____ From who? _____
 When (Start and finish): _____ For what problem(s)? _____

List past psychiatric medications: _____
 Have you been hospitalized for psychological problems? _____ When? _____
 Where were you hospitalized? _____

Have you ever attempted suicide? _____ When? _____
How? _____

Circle substances you currently use (Even if only occasionally or in small amounts):

Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers
Amphetamines ("Speed") Crank Crack Cocaine Opiates (Heroin, Opium, Codeine, etc.)
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust") Other: _____

Circle substances you have taken in the past (Even if only occasionally or in small amounts):

Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers
Amphetamines ("Speed") Crank Crack Cocaine Opiates (Heroin, Opium, Codeine, etc.)
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust") Other: _____

Have you had a prior psychological or neuropsychological evaluation? Yes ___ No ___ If yes, complete this information:

Name of psychologist: _____

Address: _____

Phone: _____ Date of and reason for this
evaluation: _____

Findings of the evaluation: _____

DOCTORS NOTES

Birth and Developmental History

Place of Birth: _____ Were parents married at time of birth? _____
Was mother under a doctors care during the pregnancy? _____ Was the child adopted? _____ If so, at what age? _____

Circle any illnesses during pregnancy:

Anemia Toxemia Herpes Measles German measles Bleeding
Kidney disease Heart disease Hypertension Abdominal trauma Infection Diabetes

Medications taken during pregnancy: _____

Were drugs or alcohol taken during pregnancy? Yes ___ No ___ If yes, specify: _____

Was there significant emotional stress during pregnancy? Yes ___ No ___ If yes, name stressors: _____

Was the birth: On time ___ Premature ___ (By how long _____) Late ___ (By how long _____)

Was labor: Spontaneous ___ Induced ___ Duration of labor _____ (Hours) Cesarean
required? _____

Was the presentation: Normal ___ Breech ___ Transverse (Crosswise) ___ Posterior first ___

Did the baby experience any of these problems: Fetal distress ___ Prolapsed cord ___ Low placenta (Placenta previa)
Premature separation of the placenta (Abruptio placenta) ___ Cord wrapped around neck ___

Any other problems that mother or child had: _____

Was general anesthesia used? _____ Were forceps used? _____ Were there breathing
problems? _____

Birthweight: _____ Length: _____

Circle those that apply to the first few weeks after birth:

Excessive sleeping Laziness Irritability Excessive crying Stiffness Limpness Tremors Twitching
Feeding difficulties Vomiting Jaundice

Other _____

Transfusions required? _____ Medication required? (For what) _____ Surgery required? (For what) _____

Give approximate ages that developmental milestones were achieved:

Head control _____ Rolled over _____ Sat alone _____ Walked _____ Run _____
Said first word _____ Used sentences _____ Self feeding w/ utensils _____ Toilet trained _____
Dress self _____ Tie shoes _____ Color within lines _____

Circle any problems that occurred in later development:

Hearing Speaking Stuttering Reading Writing Spelling Arithmetic Behavior Hyperactivity
Attentional difficulties Seizures Coordination

List family members with developmental or learning problems: _____

Medical History

Please check all the conditions that have been diagnosed as a child or an adult.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS, ARC or HIV+ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune system disease | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Enzyme deficiency | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abscessed ears | <input type="checkbox"/> Fevers (104 or higher) | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Head injury or concussion | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Senility (Dementia) |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Hereditary disorder | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Brain disease/infection | <input type="checkbox"/> Headaches | <input type="checkbox"/> Measles | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Colds (excessive) | <input type="checkbox"/> Huntington's disease | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Carbon monoxide poisoning | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Oxygen deprivation | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hazardous substance exposure | | |
| <input type="checkbox"/> Other medical/physical problems _____ | | | |

Have you ever been diagnosed with epilepsy or a seizure disorder Yes ___ No ___

If yes, check the one you have been diagnosed with.

PARTIAL GENERALIZED ___ UNCLASSIFIED TYPE

List any medications currently being taken (over-the-counter or prescription), and the dosage.

Medication and Dosage

- 1) _____ 4)
- 2) _____ 5)
- 3) _____ 6)

List any medications you are ALLERGIC or sensitive to:

Past Hospitalizations (When, where and for what):

Outpatient Surgeries (When, where and for what):

Name of family physician: _____

Address: _____ Phone: _____

Date of your last medical check-up: _____

Family History

Father's Name _____ Age _____ Health Problems _____

Education _____ Occupation _____ Employer _____

Mother's Name _____ Age _____ Health Problems _____

Education _____ Occupation _____ Employer _____

Date of parent's marriage _____ Years married _____ Current marital problems? _____

If separated, give date _____ If divorced, date _____

Previous marriages? (Father) _____ (Mother) _____ Subsequent marriages? (Father) _____ (Mother) _____

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Names and ages of brothers and sisters (Include step-brothers and step-sisters):

List anyone else who lived in the home during your childhood:

List names of any family members (E.G. Immediate and distant relatives) with any of the following problems:

Alcohol/drug abuse

Criminal history

Emotional/behavioral problems

Medical problems (e.g. Heart disease, Cancer, Seizures)

Learning/developmental problems

DOCTORS NOTES

Marital History

Marital Status: Single Married Separated Divorced Widowed

Current Marriage

Date of marriage: _____ Number of years married: _____ Date of separation: _____ Date of divorce: _____

Spouse's name: _____ Age: _____ Health: _____

Education: _____ Occupation: _____

Type of marital problems: _____

Names and ages of children: _____

If divorced/separated, what is the custody arrangement: _____

Prior Marriage

Date of marriage: _____ Number of years married: _____ Date of separation: _____ Date of divorce: _____

Spouse's name: _____ Age: _____ Health: _____

Education: _____ Occupation: _____

Type of marital problems: _____

Names and ages of children: _____

If divorced/separated, what is the custody arrangement: _____

Prior Marriage

Date of marriage: _____ Number of years married: _____ Date of separation: _____ Date of divorce: _____

Spouse's name: _____ Age: _____ Health: _____

Education: _____ Occupation: _____

Type of marital problems: _____

Names and ages of children: _____

If divorced/separated, what is the custody arrangement: _____

List any other marriages and children: _____

List names of spouses or children with the following problems:

Developmental/Learning problems: _____

Emotional/Behavioral problems: _____

Alcohol/Drug abuse: _____

Medical problems: _____

DOCTORS NOTES

Social History

If single or separated, are you currently dating anyone? _____ How long? _____ Is it a serious relationship? _____
First name: _____ Are you currently sexually active? _____ If not dating, when was your last date? _____
How long did you date that person? _____ Was it a serious relationship? _____ First name: _____

Please list "significant others" you have lived with but not married.

Current/Most Recent Cohabitation

Date began: _____ Number of years together: _____ Date ended: _____
Name : _____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement:

Prior Cohabitation

Date began: _____ Number of years together: _____ Date ended: _____
Name : _____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement:

Have you lived with anyone else in the past? ___ Yes ___ No How many times? _____
Any other children outside of marriage? ___ Yes ___ No
Names/Ages: _____
Any aborted pregnancies/miscarriages? ___ Yes ___ No When? _____

List clubs and community/business organizations you are involved with and how often you attend:

Do you attend church/Temple? (where and how often)

What do you do with your free time (including hobbies and extracurricular interests):

When was your last vacation (Please describe): _____

How many close friends do you have in the community: _____ How often do you get together with friends or family:

How long have you lived in the community: _____ Where have you lived in the past: _____

Educational History

Current grade (Or highest grade/degree completed): _____ Current school: _____
Past schools attended (List in order): _____

Hardest subject(s): _____ Favorite subject(s): _____
Grades earned in elementary school: _____ Junior High G.P.A _____ High School G.P.A. _____
College GPA _____ Grades repeated: _____

Learning problems (what subjects):

Special education placement (Type): _____ During which grades: _____
Extracurricular activities (Music, Sports, Clubs, etc.)

Expulsions/suspensions/conduct problems (Type of problem and date):

Additional schooling or non-academic training:

Occupational History

Present employer: _____ Position: _____

Length of employment: _____ Hours worked per week _____

Current responsibilities: _____

List previous employment for last ten years (Include dates and type of work):

Have you ever been terminated from a job (Please explain): _____

At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)?

Yes ___ No ___ If yes, explain: _____

Have you ever been injured on the job? Yes ___ No ___ If yes, explain: _____

DOCTORS NOTES

Legal History

Present legal problems (Describe):

Past arrests (For what?):

Convictions (For what?):

Time served in juvenile hall, jail or prison (Give dates and locations):

Military Service

Branch of service: _____ Dates of service: _____

Job(s) within service:

Highest rank: _____ Rank at discharge: _____ Discharge status: _____

Were you exposed to any dangerous or unusual substances (e.g. Agent Orange, Radiation, etc.) Yes ___ No ___

If yes, explain:

Did you sustain any physical injuries in the military? Yes ___ No ___ If yes, explain: