Adult History Questionnaire

Please complete this questionnaire to the best of your ability. Any questions of which you are unsure of the answer you may leave blank.

Bring this questionnaire with you to your appointment.

Name_____ Today's Date_____

Address_____

_____

Phone (H)_____ (W)_____ Gender M F

Hand (Writing) R L Date of Birth:_____

First Language _____ Secondary Language _____

Ethnic or Racial Background _____

Medical Diagnosis (if any) 1) _____

2) _____

Date of Diagnosis _____

At this time, do you have any concerns about your thinking abilities? Yes____ No____

At this time, do you have any concerns about your emotional state? Yes____ No ____

If yes to either, please describe:_____

_____

Form Completed by _____ Relationship _____

Phone (H) _____ Phone (W) _____

BIRTH AND DEVELOPMENTAL HISTORY

Where were you born? _____

Where were you raised?_____

You were born: On time____ Prematurely ____ Late ____

Your weight at birth: ____lbs. _____oz.

Were there any complications associated with your birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illness, etc.)?

Yes _____ No_____

If yes, please describe: _____

_____

Check all that applied to your mother while she was pregnant with you:

____ Accident

____ Alcohol use

____ Cigarette smoking

____ Drug use(marijuana, amphetamine, cocaine, LSD etc.)

____ Illness (toxemia, diabetes, high blood pressure, Rh incompatibility, etc.)

____ Poor nutrition

____ Psychological problems

____ Other problems: _____

List all medications (prescribed or over-the counter) your mother took while pregnant:_____

_____

During her pregnancy, did your mother live near a polluted area (e.g. toxic waste dump) or other hazardous area (e.g. nuclear plant, industrial area, pesticide sprayed area, etc.)
If yes, please describe:_____

Yes _____ No _____

To your knowledge, when did you develop the following skills:

	Early	Average	Late
Walking	____	_____	_____
Language	____	_____	_____
Toilet Training	____	_____	_____
Overall development	____	_____	_____

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

___ Attention problems ___ Head injury ___Muscle tightness or weakness
___ Clumsiness ___ Hearing problems ___Speech problems
___ Developmental delay ___ Hyperactivity ___ Vision problems
___ Frequent ear infections ___ Learning disability
___ Other problems: _____

MEDICAL HISTORY

Childhood Medical History

Check all of the conditions you experienced as a child. Please add details below (e.g. age of onset, treatment, etc.):

___ Allergies ___ Epilepsy or seizures ___ Pneumonia
___ Asthma ___ Fevers (104º For higher) ___ Poisoning
___ Brain infection or disease ___ Heart problems ___ Polio
___ Cancer ___ Immune system disease ___ Rheumatic fever
___ Cerebral palsy ___ Kidney problems ___ Scarlet fever
___ Chicken pox ___ Lung (respiratory) disease ___ Tuberculosis
___ Colds (excessive) ___ Measles ___ Venereal disease
___ Diabetes ___ Meningitis ___ Whooping cough
___ Encephalitis
___ Other diseases or disabilities: _____

If you checked yes to any of the above please provide details: _____

_____

_____

As a child, were you exposed to excessive amounts of lead (e.g. eating paint chips, living next to high concentrations of automotive exhaust fumes, etc.)?

Yes ___ No ___
If yes, please describe: _____

_____

As a child, did you have an accident, which required a hospital visit?
Yes ___ No ___

If yes, please describe: _____

_____

Did you ever suffer a serious injury to your head?
Yes ___ No ___

If yes, explain the circumstances and any problems you had afterwards: _____

_____

How would you describe your nutrition as a child and adolescent?
Excellent ___ Average ___ Poor ___

List the medications that were regularly given to you as a child:

Medication	Reason For Medication
_____	_____
_____	_____
_____	_____
_____	_____

Adult Medical History

Check all of the conditions you experienced as an adult. Please add details below (e.g. age of onset, treatment, etc.):

___Allergies	___Hazardous substance exposure	___Oxygen deprivation
___Asthma	___Heart Disease	___Poisoning
___Arteriosclerosis (artery disease)	___Huntington's Disease	___Polio
___Blood Disorder	___Hypertension	___Psychiatric Problems
___Brain infection or disease	___Kidney problems	___Radiation exposure
___Cancer or chemotherapy	___Lung (respiratory) disease	___Senility (Dementia)
___Diabetes	___Malnutrition	___Stroke or TIA
___Encephalitis	___Multiple Sclerosis	___Thyroid Disease

___Other diseases or disabilities:_____

If you checked yes to any of the above please provide details: _____

_____

_____

As an adult, did you have an accident that required a hospital visit?

Yes___ No___

If yes, please describe: _____

_____

List any prescription or over-the-counter medications you are currently taking and the dosages:

	Name	Dosage	Reason
a)	_____	_____	_____
b)	_____	_____	_____
c)	_____	_____	_____
d)	_____	_____	_____
e)	_____	_____	_____
f)	_____	_____	_____

Do you have epilepsy or a seizure disorder? Yes _____ No _____

If yes, check the one the appropriate type:

PARTIAL	GENERALIZED	UNCLASSIFIED ___
____ Simple partial (Jacksonian)	____ Absence (Petit mal)	
____ Complex partial (Psychomotor)	____ Myoclonic	
____ Partial evolving into generalized	____ Clonic	
	____ Tonic	
	____ Tonic-clonic (Grand mal)	
	____ Atonic	

___ I have a seizure disorder, but I don't know which type.

Please describe it:

_____

Have you had a prior psychological or neuropsychological evaluation? Yes ___ No ___

Psychologist _____

Address _____

_____

Date and reason for evaluation _____

Findings _____

Check all medical procedures that have been done:

	Check if Normal	Date	Abnormal Findings
___ Angiogram	____	_____	_____
___ Blood work	____	_____	_____
___ CT Scan	____	_____	_____
___ Lumbar Puncture or spinal Tap	____	_____	_____
___ MRI	____	_____	_____
___ Neurological Examination	____	_____	_____
___ PET Scan	____	_____	_____
___ SPECT	____	_____	_____
___ Physical Examination	____	_____	_____
___ Skull x-ray	____	_____	_____
___ Ultrasound	____	_____	_____
___ Other Tests	____	_____	_____

Have you had surgery? Yes____ No____

If yes, please describe:
_____

Date of surgery_____

FAMILY HISTORY

Mother

Is your mother alive? Yes_____ No_____

If deceased, what was the cause of death? _____

Mother's occupation: __ _____

Mother's level of education: _____

Mother's hobbies: _____

Does your mother have a known or suspected learning disability? Yes_____ No_____

If yes, describe: _____

Briefly describe your mother's health history: _____

Father

Is your father alive? Yes ____ No ____

If deceased, what was the cause of death? _____

Father's occupation: _____

Father's level of education: _____

Father's hobbies: _____

Does your father have a known or suspected learning disability? Yes ____ No ____

If yes, describe: _____

Briefly describe your father's health history:
_____

When you were born, what was your mother's age ____ Father's age ____
How many brothers and sisters do you have? _____

Where are you in the birth order? _____

Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters?

Yes ____ No _____

If yes, describe: _____

_____

Who raised you?

____ Biological parents ____ Relatives ____ Foster parents
____ Biological mother ____ Adoptive parents ____ Institutional setting
____ Biological father
____ Biological parent plus other person
____ Others: who? _____

What languages were spoken in your home when you were a child?

1) _____ 2) _____
primary language secondary language

Please check all the conditions that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles), note who it was, and describe the problem where indicated.

	Who	Describe
Neurologic (brain) diseases		
___ Alzheimer's disease or senility	_____	_____
___Huntington's disease	_____	_____
___Multiple sclerosis	_____	_____
___Parkinson's disease	_____	_____
___Epilepsy or seizures	_____	_____
___Other neurologic disease	_____	_____
Psychiatric Illness		
___Alcoholism	_____	_____
___Bipolar illness (manic-depression)	_____	_____
___Depression	_____	_____
___Personality disorder	_____	_____
___Schizophrenia	_____	_____
___Other psychiatric illness	_____	_____
Other		
___Learning disability	_____	_____
___Left-handedness	_____	_____
___Intellectual Disability	_____	_____
___Speech or language disorder	_____	_____
___Other major disease or disorder	_____	_____

PERSONAL HISTORY

Marital History

Current marital status: Married _____ Single _____ Divorced _____

Widowed ____ Separated_____ Common-Law ____

Years married to current spouse: _____

Number of times married: _____

Spouse's name: _____ Spouse's age: _____

Spouse's occupation: _____

Spouse's health: Excellent_____ Good_____ Poor _____

Not married, but living with partner: Yes ____ No _____ His/her age: ____
His/her health: Excellent ___ Good ___ Poor ___

His/her occupation: _____

Children

Name	Age	General Health and Behavior
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who currently resides with you? _____

EDUCATIONAL HISTORY

Highest grade or degree earned: _____ Field: _____

Grades achieved (with any additional comments):

____ A & B _____
____ B & C _____
____ C & D _____
____ D & F _____

Best subject _____ Worst subject _____

Did you ever repeat or skip a grade? Yes _____ No _____

Comments: _____

Did you ever receive special (remedial) classes or tutors? Yes _____ No _____

Comments: _____

OCCUPATIONAL HISTORY

Current occupation: _____

How long have you had this job? _____

Job responsibilities: _____

Prior Jobs	Responsibilities	Time on Job
a) _____	_____	
b) _____	_____	_____

c) _____ _____

At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc)?

Yes ____ No ____

If yes, explain: _____

RECREATION & DAILY LIVING

What types of recreation do you enjoy/How do you spend your time?:
_____

Do you currently need help with daily activities (i.e. dressing, cooking, driving)?
Yes ____ No ____
Comments: _____

SUBSTANCE USE HISTORY

Alcohol

I started drinking regularly at age:
Less than 10 years old ___ 10-15 ___ 16-18 ___ 19-20 ___ 21or over____

I drink alcohol:
rarely or never ___ 1-2 days/week ____ 3-5 days/week ____ Daily ____

I used to drink but have I stopped on : (date) _____

Preferred type(s) of drinks: _____

Usual number of drinks I have at a time: _____

My last drink was: less than 24 hours ago ___ 24-48 hours ago ___ Over 48 hours ago __

Check all that apply:

____ I can drink more than most people my age and size before I get drunk.

____ I sometimes get into trouble (fights, difficulty, problems at work, conflicts with family, accidents, etc.) after drinking.

____ I sometimes blackout after drinking.

____ I have had a seizure after drinking.

____ I have missed work or social engagements because of my drinking.

____ I have been arrested for DUI.

____ I have experienced the DT's after I stopped drinking.

____ I have been in treatment to quit drinking.

If you checked yes to any of the above please provide details: _____

_____

_____

Tobacco

I started smoking regularly at age:

Less than 10 years old ___ 10-15 ___ 16-18 ___ 19-20 ___ 21 or over ___

How many cigarettes do you smoke daily? _____

Drugs

Please check all the drugs you are now using or have used in the past:

		Presently Using	Used in past
____	Amphetamines (including diet pills)	___	___
____	Barbiturates (downers etc.)	___	___
____	Cocaine or crack	___	___
____	Hallucinogenics (LSD, acid, STP, etc.)	___	___
____	Inhalants (glue, paint, nitrous oxide, etc.)	___	___
____	Marijuana	___	___
____	Opiate narcotics (heroin, morphine, etc.)	___	___
____	PCP (or "angel dust")	___	___

Please list any other drugs:

_____

Do you consider yourself dependent on any **above** drugs? Yes ____ No ____

Which one(s)? _____

Do you consider yourself dependent on any **prescription** drugs? Yes ____ No ____

Which one(s)? _____

Check all that apply:

____ I have gone through drug withdrawal
____ I have used I.V. drugs.
____ I have been in drug treatment.

PSYCHIATRIC HISTORY

Check all of the conditions you currently experience or have experienced in the past. Please add details below (e.g. age of onset, treatment, etc.):

____	Depression	____	Eating Disorder
____	Anxiety	____	Obsessive Compulsive Disorder
____	Phobias	____	Bipolar Illness/Manic Depression
____	Schizophrenia	____	Personality Disorder
____	Other	____	None

If you checked yes to any of the above, please provide details: _____

_____

_____

Do you currently or have you in the past taken medication for a psychiatric disorder?

____ Yes _____ No

If yes, please list medications: _____

_____

Do you currently or have you in the past participated in psychotherapy or counseling?

____ Yes ____ No

If yes, please indicate type of counseling, dates and effectiveness: _____

_____

_____

Have you ever been hospitalized in an inpatient psychiatric facility?

____ Yes ____ No

Is there any other aspect of your mental health history that you consider important for us to know?

_____

_____

_____

Thank you for taking the time to complete this form. It provides valuable information regarding your personal history.