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ADULT HISTORY

NAME: _____ TODAY'S DATE: _____

BIRTH DATE: _____ AGE: _____

GENDER: (circle) Male Female Other_____ MARITAL STATUS: _____

ETHNICITY: _____

HOME ADDRESS: _____

EMAIL ADDRESS: _____

CELL PHONE: _____ HOME PHONE: _____ BUSINESS PHONE: _____

OCCUPATION: _____ PLACE OF BUSINESS: _____

BUSINESS ADDRESS: _____

WHO REFERRED YOU HERE? _____ PHONE: _____

ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

REASON FOR VISIT

Briefly describe the nature of your current concerns or difficulties: _____

For how long has this problem been a concern?: _____

When was this problem first noticed? _____

What seems to help the problem? _____

REASON FOR VISIT (CONTINUED)

What seems to make the problem worse? _____

_____

Have any other family members had similar problems? YES NO If yes, whom? _____

_____

Have you ever received evaluation or treatment for the current problems or similar problems? YES NO

If yes, when and with whom? _____

_____

If currently, list address: _____

EDUCATION HISTORY

SCHOOLS ATTENDED	DATES	DEGREES

Special Education: YES NO If yes, type of class: _____

PERSONAL HISTORY

Briefly describe your work history, starting as far back as you can remember with your first paid job. (*eg. Server, Ages 18-19, Restaurant*)

POSITION	AGES	EMPLOYER

Have you ever served in the military? YES NO

If yes, details (highest rank, special honors, duties, discharge status): _____

_____

_____

Have you ever been in trouble with the law? YES NO If yes, describe: _____

_____

_____

PERSONAL HISTORY (CONTINUED)

Sexual Orientation:_____

Are you currently in an intimate relationship? YES NO If yes, for how long?_____

Do you have trouble in your relationships with others? YES NO If yes, in what way?:_____

_____

_____

_____

Approximately, how many intimate relationships have you had that lasted more than three months?_____

Do you have any children? YES NO

Name: _____ Age: _____ M F Biological? YES NO

Name: _____ Age: _____ M F Biological? YES NO

Name: _____ Age: _____ M F Biological? YES NO

Name: _____ Age: _____ M F Biological? YES NO

DEVELOPMENTAL HISTORY (INFANCY/CHILDHOOD)

As far as you know, were there any problems with your mother's pregnancy or delivery of you? YES NO

If yes, details: _____

_____

As far as you know, did you sit up, walk, talk, and make major developmental milestones on time? YES NO

If no, were you early or late? Please describe: _____

_____

_____

As far as you recall, did you go through puberty significantly earlier, on time, or significantly later than most of your same age peers? ____EARLIER THAN MOST ____ON TIME WITH MOST ____LATER THAN MOST

_____

_____

Did you have any significant childhood illnesses or accidents? YES NO

If yes, please describe: _____

_____

_____

_____

Do you feel you had reasonably normal relationships with your peers when you were a child? YES NO

If no, please describe: _____

_____

MEDICAL HISTORY

Place a check next to any illness or condition that you have had. When you check an item, also note your approximate age at the time of the illness.

ILLNESS OR CONDITION	AGES	ILLNESS OR CONDITION	AGES
____ Addiction or drug dependence	_____	____ Headaches	_____
____ AIDS or HIV positive	_____	____ Heart disease or problems	_____
____ Allergies	_____	____ Herpes	_____
____ Anemia	_____	____ High blood pressure	_____
____ Aneurysm	_____	____ Jaundice	_____
____ Arteriovenous/Chiari Malformation (AVM)	_____	____ Lead poisoning	_____
____ Arthritis	_____	____ Leukemia	_____
____ Asthma	_____	____ Malnutrition	_____
____ Ataxia	_____	____ Meningitis	_____
____ Automobile accident	_____	____ Muscular disease	_____
____ Back pains or problems	_____	____ Pain problems (_____)	_____
____ Bleeding problems	_____	____ Paralysis	_____
____ Bone or joint disease	_____	____ Pituitary disorder	_____
____ Broken bones	_____	____ Pneumonia	_____
____ Cancer	_____	____ Poisoning	_____
____ Chorea (movement disorder)	_____	____ Poliomyelitis	_____
____ Coma	_____	____ Respiratory illness	_____
____ Cystic Fibrosis	_____	____ Rheumatoid Arthritis	_____
____ Dazed or unconscious	_____	____ Scarlet fever	_____
____ Dementia	_____	____ Sensory losses (hearing, eye sight)	_____
____ Diabetes	_____	____ Sexual molestation	_____
____ Dysarthia (language disorder)	_____	____ Sexually transmitted disease (STD)	_____
____ Dyspraxia (or Apraxia)	_____	____ Sinus infections	_____
____ Ear infections (PE tubes)	_____	____ Speech and language problems	_____
____Other ear or hearing problems	_____	____ Spells or fits (_____)	_____
____ Eczema or hives	_____	____ Stroke	_____
____ Electrical or chemical shock	_____	____ Substance dependence	_____
____ Encephalitis	_____	____ Suicide attempts or thoughts	_____
____ Epilepsy, seizures or convulsions	_____	____ Sunstroke or heat exhaustion	_____
____ Fainting spells	_____	____ Thyroid disorder or problem	_____
____ Fetal Alcohol Syndrome	_____	____ Tuberculosis	_____
____ Fever (if very high or prolonged)	_____	____ Tumor	_____
____ Gender Transition	_____	____ Visual or eye problems	_____
____ Guillan-Barré Syndrome	_____	____ Whooping cough	_____
____ Head injury	_____	____ Other: _____	

Other major medical problems not mentioned (accidents, illnesses, or syndromes): _____

_____

Indicate if you have undergone any of these medical tests in the past (place check and give approximate age or ages when test was given):

TEST	AGE	TEST	AGE
____ Academic/Educational testing	_____	____ Chromosome study	_____
____ Psychological testing	_____	____ Ultrasound	_____
____ Electroencephalogram (EEG)	_____	____ Skull or Head X-rays	_____
____ Evoked Potentials (ERP)	_____	____ CT scans (_____)	_____
____ Ophthalmology (vision) evaluation	_____	____ MRI scans (_____)	_____
____ Audiology (hearing) evaluation	_____	Other: _____	_____

MEDICAL HISTORY (CONTINUED)

On a scale from 1 to 10, how would you rate your overall physical health?

Not All Healthy . . . . . Very Healthy

1 2 3 4 5 6 7 8 9 10

If you gave yourself less than 8, why? _____

_____

Have you ever suffered from a head injury which caused confusion or loss of consciousness? YES NO

If yes, when was this?_____

CURRENT PHYSICIAN NAME(S) / SPECIALTY

_____

_____

MEDICATION HISTORY

How much do you smoke or use tobacco now?_____

If none, have you ever been a smoker? YES NO _____ Tobacco _____ Marijuana

Do you use marijuana? YES NO Describe frequency: _____

How many drinks containing alcohol do you consume per week? _____ In one sitting? _____

How much caffeine do you drink, including caffeinated tea and soda? (in cups) _____

Other drug use (including street drugs used in the past year): _____

_____

Please list medications currently taken or taken within the last five years below (include over-the-counter and those prescribed by a health care provider):

MEDICATION NAME	DOSE	REASON PRESCRIBED

Please list any supplements (vitamins, herbs, minerals, etc.) you are currently taking:

SUPPLEMENT NAME	DOSE	REASON

FAMILY HISTORY

Place a check next to any illness, condition, or problem experienced by any genetic relative. When you check an item, please note the relative's relationship to you. If any problems run in the family, please write them at the end of the list.

	CONDITION	RELATIONSHIP TO PATIENT
☐	Alcoholism	
☐	Antisocial (criminal) behavior	
☐	Autism Spectrum Disorder	
☐	Asperger's Disorder, Schizoid Personality	
☐	Bipolar Disorder (manic-depressive)	
☐	Dementia or Alzheimers Disease	
☐	Depression	
☐	Drug addiction or drug problems	
☐	Heart Attack/Serious Heart Disease	
☐	Headaches (e.g. migraines)	
☐	ADHD/ADD (hyperactivity/attention problems)	
☐	Learning problems	
☐	Developmental delay/mental retardation	
☐	Tic or movement disorders	
☐	Schizophrenia or psychosis	
☐	Seizures, epilepsy, or convulsions	
☐	Sexual/physical abuse in childhood	
☐	Stroke, aneurism, brain thrombosis	
☐	Suicide or suicide attempt	
☐	Borderline or Narcissistic Personality Disorder	
☐	Post-Traumatic Stress Disorder (PTSD)	
☐	Obsessive Compulsive Disorder (OCD)	
☐	Nervous or neurological illness	
☐	Other mental illness (_____)	
☐	Other (specify_____)	

OTHER COMMENTS

You have been asked a lot of questions. Can you think for a minute and describe any other problems you have that might be related to what you are here for? _____

_____