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ADULT HISTORY

NAME: _____ TODAY'S DATE: _____
BIRTH DATE: _____ AGE: _____
GENDER: Male Female PRONOUNS: _____ MARITAL STATUS: _____
ETHNICITY: _____
HOME ADDRESS: _____
EMAIL ADDRESS: _____
CELL PHONE: _____ HOME PHONE: _____ BUSINESS PHONE: _____
OCCUPATION: _____ PLACE OF BUSINESS: _____
BUSINESS ADDRESS: _____
WHO REFERRED YOU? _____ 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
<input type="checkbox"/> Addiction or drug dependence	_____	<input type="checkbox"/> Headaches	_____
<input type="checkbox"/> AIDS or HIV positive	_____	<input type="checkbox"/> Heart disease or problems	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Herpes	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Aneurysm	_____	<input type="checkbox"/> Jaundice	_____
<input type="checkbox"/> Arteriovenous/Chiari Malformation (AVM)	_____	<input type="checkbox"/> Lead poisoning	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Leukemia	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Malnutrition	_____
<input type="checkbox"/> Ataxia	_____	<input type="checkbox"/> Meningitis	_____
<input type="checkbox"/> Automobile accident	_____	<input type="checkbox"/> Muscular disease	_____
<input type="checkbox"/> Back pains or problems	_____	<input type="checkbox"/> Pain problems (_____)	_____
<input type="checkbox"/> Bleeding problems	_____	<input type="checkbox"/> Paralysis	_____
<input type="checkbox"/> Bone or joint disease	_____	<input type="checkbox"/> Pituitary disorder	_____
<input type="checkbox"/> Broken bones	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Poisoning	_____
<input type="checkbox"/> Chorea (movement disorder)	_____	<input type="checkbox"/> Poliomyelitis	_____
<input type="checkbox"/> Coma	_____	<input type="checkbox"/> Respiratory illness	_____
<input type="checkbox"/> Cystic Fibrosis	_____	<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Dazed or unconscious	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Dementia	_____	<input type="checkbox"/> Sensory losses (hearing, eye sight)	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Sexual molestation	_____
<input type="checkbox"/> Dysarthria (language disorder)	_____	<input type="checkbox"/> Sexually transmitted disease (STD)	_____
<input type="checkbox"/> Dyspraxia (or Apraxia)	_____	<input type="checkbox"/> Sinus infections	_____
<input type="checkbox"/> Ear infections (PE tubes)	_____	<input type="checkbox"/> Speech and language problems	_____
<input type="checkbox"/> Other ear or hearing problems	_____	<input type="checkbox"/> Spells or fits (_____)	_____
<input type="checkbox"/> Eczema or hives	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Electrical or chemical shock	_____	<input type="checkbox"/> Substance dependence	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Suicide attempts or thoughts	_____
<input type="checkbox"/> Epilepsy, seizures or convulsions	_____	<input type="checkbox"/> Sunstroke or heat exhaustion	_____
<input type="checkbox"/> Fainting spells	_____	<input type="checkbox"/> Thyroid disorder or problem	_____
<input type="checkbox"/> Fetal Alcohol Syndrome	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Fever (if very high or prolonged)	_____	<input type="checkbox"/> Tumor	_____
<input type="checkbox"/> Gender Transition	_____	<input type="checkbox"/> Visual or eye problems	_____
<input type="checkbox"/> Guillan-Barré Syndrome	_____	<input type="checkbox"/> Whooping cough	_____
<input type="checkbox"/> Head injury	_____	<input type="checkbox"/> 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
<input type="checkbox"/> Academic/Educational testing	_____	<input type="checkbox"/> Chromosome study	_____
<input type="checkbox"/> Psychological testing	_____	<input type="checkbox"/> Ultrasound	_____
<input type="checkbox"/> Electroencephalogram (EEG)	_____	<input type="checkbox"/> Skull or Head X-rays	_____
<input type="checkbox"/> Evoked Potentials (ERP)	_____	<input type="checkbox"/> CT scans (_____)	_____
<input type="checkbox"/> Ophthalmology (vision) evaluation	_____	<input type="checkbox"/> MRI scans (_____)	_____
<input type="checkbox"/> Audiology (hearing) evaluation	_____	<input type="checkbox"/> 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
<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> Antisocial (criminal) behavior	_____
<input type="checkbox"/> Autism Spectrum Disorder	_____
<input type="checkbox"/> Asperger's Disorder, Schizoid Personality	_____
<input type="checkbox"/> Bipolar Disorder (manic-depressive)	_____
<input type="checkbox"/> Dementia or Alzheimers Disease	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Drug addiction or drug problems	_____
<input type="checkbox"/> Heart Attack/Serious Heart Disease	_____
<input type="checkbox"/> Headaches (e.g. migraines)	_____
<input type="checkbox"/> ADHD/ADD (hyperactivity/attention problems)	_____
<input type="checkbox"/> Learning problems	_____
<input type="checkbox"/> Developmental delay/mental retardation	_____
<input type="checkbox"/> Tic or movement disorders	_____
<input type="checkbox"/> Schizophrenia or psychosis	_____
<input type="checkbox"/> Seizures, epilepsy, or convulsions	_____
<input type="checkbox"/> Sexual/physical abuse in childhood	_____
<input type="checkbox"/> Stroke, aneurism, brain thrombosis	_____
<input type="checkbox"/> Suicide or suicide attempt	_____
<input type="checkbox"/> Borderline or Narcissistic Personality Disorder	_____
<input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)	_____
<input type="checkbox"/> Obsessive Compulsive Disorder (OCD)	_____
<input type="checkbox"/> Nervous or neurological illness	_____
<input type="checkbox"/> Other mental illness (_____)	_____
<input type="checkbox"/> 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? _____
