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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
☐ Addiction or drug dependence	
☐ AIDS or HIV positive	
☐ Allergies	
☐ Anemia	
☐ Aneurysm	
☐ Arteriovenous/Chiari Malformation (AVM)	
☐ Arthritis	
☐ Asthma	
☐ Ataxia	
☐ Automobile accident	
☐ Back pains or problems	
☐ Bleeding problems	
☐ Bone or joint disease	
☐ Broken bones	
☐ Cancer	
☐ Chorea (movement disorder)	
☐ Coma	
☐ Cystic Fibrosis	
☐ Dazed or unconscious	
☐ Dementia	
☐ Diabetes	
☐ Dysarthia (language disorder)	
☐ Dyspraxia (or Apraxia)	
☐ Ear infections (PE tubes)	
☐ Other ear or hearing problems	
☐ Eczema or hives	
☐ Electrical or chemical shock	
☐ Encephalitis	
☐ Epilepsy, seizures or convulsions	
☐ Fainting spells	
☐ Fetal Alcohol Syndrome	
☐ Fever (if very high or prolonged)	
☐ Gender Transition	
☐ Guillan-Barré Syndrome	
☐ Head injury	

ILLNESS OR CONDITION	AGES
☐ Headaches	
☐ Heart disease or problems	
☐ Herpes	
☐ High blood pressure	
☐ Jaundice	
☐ Lead poisoning	
☐ Leukemia	
☐ Malnutrition	
☐ Meningitis	
☐ Muscular disease	
☐ Pain problems (_____)	
☐ Paralysis	
☐ Pituitary disorder	
☐ Pneumonia	
☐ Poisoning	
☐ Poliomyelitis	
☐ Respiratory illness	
☐ Rheumatoid Arthritis	
☐ Scarlet fever	
☐ Sensory losses (hearing, eye sight)	
☐ Sexual molestation	
☐ Sexually transmitted disease (STD)	
☐ Sinus infections	
☐ Speech and language problems	
☐ Spells or fits (_____)	
☐ Stroke	
☐ Substance dependence	
☐ Suicide attempts or thoughts	
☐ Sunstroke or heat exhaustion	
☐ Thyroid disorder or problem	
☐ Tuberculosis	
☐ Tumor	
☐ Visual or eye problems	
☐ Whooping cough	
☐ 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
☐ Academic/Educational testing	
☐ Psychological testing	
☐ Electroencephalogram (EEG)	
☐ Evoked Potentials (ERP)	
☐ Ophthalmology (vision) evaluation	
☐ Audiology (hearing) evaluation	

TEST	AGE
☐ Chromosome study	
☐ Ultrasound	
☐ Skull or Head X-rays	
☐ CT scans (_____)	
☐ MRI scans (_____)	
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? _____

_____