

Adult History Form

Name: _____ Date: _____

Address: _____
(street address)

_____ Telephone: _____
(city and zip)

Sex: _____ Date of Birth: _____ Age: _____ Place of Birth: _____

Person Completing Information: _____ Relationship to Patient: _____

Primary Language: _____ Any Other Languages Spoken: _____

How do you identify racially/ethnically? _____

Employer: _____ Position: _____

School Attending: _____ Grade: _____ Major: _____

Please list current psychiatric medications and dosages: _____

Who prescribes these medications? _____ Current Therapist: _____

1. Please identify problem(s): _____

2. When did the problem(s) begin? _____

3. List anything you did to improve the problem(s): _____

4. What questions would you like the evaluation to address? _____

Please list the names of people with whom you have lived:

<u>AS AN ADULT:</u> <u>Name</u>	<u>Age</u>	<u>Relation to You</u>	<u>Currently?</u>
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

<u>AS A CHILD:</u> <u>Name</u>	<u>Age</u>	<u>Relation to You</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are your biological parents: Divorced? _____ Separated? _____ Widowed? _____ Remarried? _____
If so, how old were you when these events occurred? _____

If the biological parents divorced, with whom did you live? Describe any changes in caretakers: _____

Were you adopted? Yes ___ No ___ If yes, at what age and explain the circumstances: _____

Mother's education level: _____ Occupation: _____ Hrs/wk: _____

Father's education level: _____ Occupation: _____ Hrs/wk: _____

Did you have a close relationship with another adult (e.g., grandparent, relative, family friend)? If so, with whom? _____

How would you describe your sibling relations as a child? _____

How often did you or your family change residences and your ages/reactions to these moves? _____

What kinds of activities did you and your family do together? _____

What activities do you enjoy currently? _____

Describe your strengths: _____

Have you ever had a psychological or psychiatric evaluation? ___ Yes ___ No. If so, when and by whom? _____

Have you attended occupational therapy, physical therapy, or speech therapy? _____

SCHOOLING

Please list schools attended:

Daycare? ___ Yes ___ No If so, at what ages? _____

Preschool? ___ Yes ___ No If so, at what ages? _____

Special Education? ___ Yes ___ No If Yes, what type? _____

<u>Academic Year</u>	<u>School Name and City/State</u>	<u>Grades Earned</u>
Kindergarten	_____	_____
1st grade	_____	_____
2nd grade	_____	_____
3rd grade	_____	_____
4th grade	_____	_____
5th grade	_____	_____
6th grade	_____	_____
7th grade	_____	_____
8th grade	_____	_____
9th grade	_____	_____
10th grade	_____	_____
11th grade	_____	_____
12th grade	_____	_____

Did you skip or repeat any grades? _____

Best school subjects: _____

Worst school subjects and any particular problem areas: _____

Did your school performance ever change dramatically? If so, please explain: _____

College(s), degrees earned, years attended, and course grades: _____

How many friends did you have as a child? None _____ 1-2 _____ Few _____ Several _____ Many _____

How would you describe your peer relations as a child? _____

PRENATAL HISTORY

Were there any significant problems in the pregnancy? ___ Yes ___ No If yes, please specify: _____

Any use of alcohol: _____

Amount: _____ How often? _____

Any use of medications or drugs (including tobacco): _____

Amount: _____ How often? _____

Length of: pregnancy _____; labor and delivery _____

Were there any complications in labor/delivery? ___ Yes ___ No If yes, please specify: _____

NEONATAL HISTORY

Birth weight: _____ Were there any significant problems for you at birth or in the newborn phase? ___ Yes ___ No. If yes, please specify: _____

INFANCY (0 to 12 months)

Check if applicable, any significant problems, delays, and/or difficulties you had in the 1st year:

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> feeding | <input type="checkbox"/> bowel and or urinary habits | <input type="checkbox"/> intolerance of affection |
| <input type="checkbox"/> sleeping | <input type="checkbox"/> inability to be consoled | <input type="checkbox"/> sitting unassisted |
| <input type="checkbox"/> breathing | <input type="checkbox"/> delay in crawling | <input type="checkbox"/> emotional responsiveness |
| <input type="checkbox"/> colic | <input type="checkbox"/> allergies/ear infections | <input type="checkbox"/> social responsiveness |

Please specify any other significant problems: _____

EARLY CHILDHOOD (1 to 3 years)

Check if applicable, any significant problems, delays, and/or difficulties you had between the ages of 1 to 3 years:

- | | | |
|--|---|--|
| <input type="checkbox"/> delay in walking unassisted | <input type="checkbox"/> feeding self | <input type="checkbox"/> allergies/ear infections |
| <input type="checkbox"/> delay in first words | <input type="checkbox"/> delay in using sentences | <input type="checkbox"/> severe temper tantrums |
| <input type="checkbox"/> entertaining self | <input type="checkbox"/> delay in toilet training | <input type="checkbox"/> self-destructive behavior |
| <input type="checkbox"/> stranger anxiety | <input type="checkbox"/> over-activity | |

Please specify any other significant problems: _____

CHILDHOOD (3 to 11 years)

Check if applicable, any significant problems, delays, and/or difficulties you displayed between the ages of 3 to 11 years:

- | | | |
|--|--|---|
| <input type="checkbox"/> impulsive | <input type="checkbox"/> aggressive | <input type="checkbox"/> self-destructive habits |
| <input type="checkbox"/> very shy | <input type="checkbox"/> nervous/fearful | <input type="checkbox"/> completing tasks, chores |
| <input type="checkbox"/> over-activity | <input type="checkbox"/> short attention span | <input type="checkbox"/> severe temper tantrums |
| <input type="checkbox"/> uncoordinated | <input type="checkbox"/> bowel/urinary habits | <input type="checkbox"/> obeying adults |
| <input type="checkbox"/> reading skills | <input type="checkbox"/> writing skills | <input type="checkbox"/> math skills |
| <input type="checkbox"/> academic failure | <input type="checkbox"/> cooperating in group activities | |
| <input type="checkbox"/> destroying property | <input type="checkbox"/> prolonged sadness or irritability | |

Please specify any other significant problems: _____

ADOLESCENCE (12 to 18 years)

Check if applicable, any significant problems, delays, and/or difficulties you displayed as a teenager in these areas:

- | | | |
|--|--|---|
| <input type="checkbox"/> prolonged sadness or irritability | <input type="checkbox"/> impulsiveness | <input type="checkbox"/> sexually active |
| <input type="checkbox"/> academic failure | <input type="checkbox"/> truancy | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> aggressiveness | <input type="checkbox"/> drug or alcohol use | <input type="checkbox"/> social isolation |
| <input type="checkbox"/> temper outbursts | <input type="checkbox"/> delinquency | <input type="checkbox"/> running away |
| <input type="checkbox"/> fighting | <input type="checkbox"/> gang membership | <input type="checkbox"/> eating/appetite |

Please specify any other significant problems: _____

