Adult History Form

Today's date: _____

Name of person completing this form: _____

Relationship to client: _____

Client's name: _____

Client's preferred name: _____

Gender assigned at birth: _____ **Gender identity:** _____

Pronouns: _____ **Phone:** _____

Address: _____
Address

_____ _____ _____
City State Zip

First Language: _____ **Language spoken at home:** _____

Right or left handed: _____ **Race:** _____ **Ethnicity:** _____

Age: _____ **Birthdate:** _____ **Is this patient a twin?** _____

Marital Status: _____ **Number of years:** _____

Current Occupation: _____

Previous Occupation: _____

Reason for Leaving: _____

Grade School

Number of years: _____ Average Grades: _____

High School

Number of years: _____ Average Grades: _____ G.E.D. or Diploma: _____

College

Name of college: _____

Field of study: _____

Number of years: _____ Average grades: _____ Degree: _____

Graduate School

Name of college: _____

Field of study: _____

Number of years: _____ Average grades: _____ Degree: _____

Any learning problems while in school? (Specifically: reading, spelling, writing, arithmetic, drawing):

What grade were you in at the time?

Have you ever been diagnosed with a learning disability, such as dyslexia? Any special classes or accommodations?

Why was the client referred for this testing? (Please include referring doctor/provider)

What questions are we hoping to have answered with this testing?

When did the problem begin? (Stroke, seizure, illness, head injury)

Current Medications: *Please include all medications, including multivitamins, supplements, melatonin, etc.*

1. _____ _____ _____
   Name Dosage Frequency

2. _____ _____ _____
   Name Dosage Frequency

3. _____ _____ _____
   Name Dosage Frequency

4. _____ _____ _____
   Name Dosage Frequency

5. _____ _____ _____
   Name Dosage Frequency

6. _____ _____ _____
   Name Dosage Frequency

7. _____ _____ _____
   Name Dosage Frequency

Discontinued Medications: (taken longer than 1 month)

1. _____ _____ _____
   Name Dosage Frequency

   Reason for discontinuation: _____

2. _____ _____ _____
   Name Dosage Frequency

   Reason for discontinuation: _____

3. _____ _____ _____
   Name Dosage Frequency

   Reason for discontinuation: _____

4. _____ _____ _____
   Name Dosage Frequency

   Reason for discontinuation: _____

Indicate if you have any of the following problems (currently or in the past). If so, please describe each including duration and the age the problem began.

Loss of consciousness:

When did this occur?

How long was the loss of consciousness?

Memory (Please describe in detail and include age on onset):

Numbness or tingling in limbs (Please describe in detail and include age of onset):

Paralysis or inability to move arms and legs (Please describe in detail and include age of onset):

Vision and/or hearing problems (Please describe in detail and include age of onset):

Changes in taste, smell, touch (Please describe in detail and include age of onset):

Work Problems (Please describe in detail and include age of onset):

Coordination difficulties or change (Please describe in detail and include age of onset):

Abnormally high fever (Please describe in detail and include age of onset):

Seizures (Please describe in detail and include age of onset):

Allergies to Medications (Please describe in detail and include age of onset):

Head Injury (Please describe in detail and include age of onset):

Broken Bones (Please describe in detail and include age of onset):

Injuries to arms, hands, and/or fingers (Please describe in detail and include age of onset):

Headaches (Please rate the severity on the scale below):

◯ **1 (Mild)** ◯ **2** ◯ **3** ◯ **4** ◯ **5 (Severe)**

How often do you have headaches?

Do you think your personality has changed in the past few years? If so, explain:

Have you ever had any of the following (Please indicate the year that it occurred):

Polio _____	**Meningitis _____**	**Huntington's Chorea _____**
Diabetes _____	**Encephalitis _____**	**High Blood Pressure _____**
Fainting _____	**Syphilis or Gonorrhea _____**	**Rheumatic or Scarlet Fever _____**

Other medical problems which are a part of your history:

Other hospitalizations (give date and reason):

Have you ever had shock treatment?

When?

Is there any history of emotional or neurological problems in your family? (Alcoholism, psychiatric hospitalizations, neurological problems.) Please describe in detail:

Family History:
Please include patient's mother, father, significant other, siblings, and household members.

1. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

2. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

3. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

4. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

5. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

6. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

7. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

8. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

9. Name _____ Relation _____ Age _____
   Years of education/degree/diploma _____ Occupation _____ Health Problems _____

10. Name _____ Relation _____ Age _____
    Years of education/degree/diploma _____ Occupation _____ Health Problems _____

Have you ever been a smoker?

How many packs per day?

How many years?

Have you quit?

How long ago did you quit?

How often do you have a drink containing alcohol?

_____ Never

_____ Once a month or less

_____ 2-4 times a month

_____ 2-3 time a week

_____ 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

_____ 1 or 2

_____ 3 or 4

_____ 5 or 6

_____ 7 or 9

_____ 10 or more

How often do you have 6 or more drinks on one occasion?

_____ Never

_____ Less than monthly

_____ Monthly

_____ Weekly

_____ Daily or almost daily

Have you quit? _____ How long ago did you quit? _____

Do you currently use or have used any of the following substances:

	Currently	In the past- please note year(s) of use
Sleeping pills	_____	_____
Phenobarbital	_____	_____
Marijuana	_____	_____
Morphine	_____	_____
Heroin	_____	_____
Cocaine	_____	_____
Other	_____	_____

Do you use toxic chemicals at home or work?

About how much sleep do you usually get in a 24-hour period (including naps)?

Do you often feel sleepy when you are supposed to be awake or active?

Do you have trouble falling asleep?

Do you snore most nights?

Has anyone noticed that you stop breathing while sleeping (witnessed apneas)?

Do you fall asleep while reading, riding in a car, or during quiet activities?

Do you have any changes in appetite?

Are you gaining weight?

Are you losing weight?

Who is primarily responsible for home chores (laundry, cooking, cleaning)?

Who is responsible for banking, shopping, errands?

What chores do you regularly do at home?

Driving an automobile. Please indicate the sentence that best describes you:

_____ I no longer drive.

_____ I am able to drive with someone present to give me directions.

_____ I drive alone but sometimes I get lost.

_____ I drive alone and have a good sense of direction and driving skills.

Any other problems with your driving (Accidents, getting lost, fear of driving at night)?

What do you do for relaxation and enjoyment?

Do you often visit with friends and relatives?

Other comments: