

Solara Psychological



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Adult History Questionnaire

Please answer all questions AS FULLY AS POSSIBLE and bring with you on the day of your appointment.

Name of person completing form: _____ Relationship to patient: _____

Patient's full name: _____ DOB: _____ Age: _____

Sex: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary/Non-Conforming ☐ Prefer not to say

Are you: ☐ Right-handed ☐ Left-handed

What do you consider to be your ethnicity? _____

Where did you grow up? _____ Birthplace? _____

Marital Status: ☐ Single

☐ Married How long? _____

☐ Life Partner How long? _____

☐ Divorced How long married? _____ How long divorced? _____

☐ Widowed How long married? _____ How long widowed? _____

Please list names & ages of all children:

Who lives in your home?

What is (are) your source(s) of income? ☐ Employment ☐ SSI ☐ General Assistance

☐ Retirement/Pension ☐ SSDI ☐ Food Stamps

☐ Other: _____

If you have applied for disability: Was it granted? ☐ Yes ☐ No If yes, when granted? _____

What was the application based on? _____

Did you learn English as your first language? ☐ Yes

☐ No At what age did you learn English? _____

What is your preferred/primary language now? _____

Current Concerns/Symptoms

For each item below, place a mark in the “Past” box if this was a problem for you in the past, and place a mark in the “Current” box if it is currently a problem for you (you can mark both “Past” and “Current” if necessary):

Attention	Past	Current	Memory	Past	Current
Easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	Trouble remembering people's names	<input type="checkbox"/>	<input type="checkbox"/>
Have to reread material	<input type="checkbox"/>	<input type="checkbox"/>	Trouble recognizing familiar faces	<input type="checkbox"/>	<input type="checkbox"/>
Losing train of thought	<input type="checkbox"/>	<input type="checkbox"/>	Trouble remembering recent events (e.g., what you had for dinner last night)	<input type="checkbox"/>	<input type="checkbox"/>
Trouble following conversations	<input type="checkbox"/>	<input type="checkbox"/>	Trouble remembering recent conversations	<input type="checkbox"/>	<input type="checkbox"/>
Losing or misplacing personal items (e.g., glasses, keys, phone)	<input type="checkbox"/>	<input type="checkbox"/>	Trouble remembering things from longer ago (e.g., couple years ago)	<input type="checkbox"/>	<input type="checkbox"/>
Trouble multitasking	<input type="checkbox"/>	<input type="checkbox"/>	Trouble learning new things	<input type="checkbox"/>	<input type="checkbox"/>
Trouble planning complex activities (e.g., a party or vacation)	<input type="checkbox"/>	<input type="checkbox"/>	Having to write notes to remember things a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>
Trouble organizing your things	<input type="checkbox"/>	<input type="checkbox"/>	Repeating yourself	<input type="checkbox"/>	<input type="checkbox"/>
Trouble planning your day	<input type="checkbox"/>	<input type="checkbox"/>	Language		
Procrastinating	<input type="checkbox"/>	<input type="checkbox"/>	Trouble thinking of the right word (“tip-of-the-tongue”)	<input type="checkbox"/>	<input type="checkbox"/>
Daydreaming or mind wandering	<input type="checkbox"/>	<input type="checkbox"/>	Using the wrong word	<input type="checkbox"/>	<input type="checkbox"/>
Trouble following multi-step instructions (e.g., a recipe)	<input type="checkbox"/>	<input type="checkbox"/>	Trouble understanding what others are saying in conversation	<input type="checkbox"/>	<input type="checkbox"/>
Trouble making decisions quickly	<input type="checkbox"/>	<input type="checkbox"/>	Slurred speech or problems w/articulation	<input type="checkbox"/>	<input type="checkbox"/>
Leaving projects unfinished	<input type="checkbox"/>	<input type="checkbox"/>	Fine Motor		
Trouble getting started on things	<input type="checkbox"/>	<input type="checkbox"/>	Trouble picking up or dropping things	<input type="checkbox"/>	<input type="checkbox"/>
Trouble getting back on track if interrupted	<input type="checkbox"/>	<input type="checkbox"/>	Trouble assembling pieces (e.g., furniture) or using tools	<input type="checkbox"/>	<input type="checkbox"/>
Spatial			Changes in your handwriting	<input type="checkbox"/>	<input type="checkbox"/>
Getting lost easily while driving, in stores or walking in your neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	Tremors or shakiness in hands/arms or other body parts	<input type="checkbox"/>	<input type="checkbox"/>
Trouble reading maps	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling in hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Trouble judging distances	<input type="checkbox"/>	<input type="checkbox"/>	Sensory		
Unsure of your body position (e.g., bumping into things, misreaching for objects)	<input type="checkbox"/>	<input type="checkbox"/>	Change in vision	<input type="checkbox"/>	<input type="checkbox"/>
Everyday Activities			Change in hearing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty driving (e.g., running lights, accidents, hitting curbs)	<input type="checkbox"/>	<input type="checkbox"/>	Change in taste or smell	<input type="checkbox"/>	<input type="checkbox"/>
Trouble remembering to take medications	<input type="checkbox"/>	<input type="checkbox"/>	Change in touch sense	<input type="checkbox"/>	<input type="checkbox"/>
Trouble managing your finances (e.g., forgetting to pay bills)	<input type="checkbox"/>	<input type="checkbox"/>	Walking/Balance		
Trouble cooking (e.g., forgetting to turn off stove, leaving ingredients out)	<input type="checkbox"/>	<input type="checkbox"/>	Feeling uncoordinated	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with housekeeping (e.g., dishes, cleaning, laundry)	<input type="checkbox"/>	<input type="checkbox"/>	Problems with balance	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with bathing, grooming, dressing (e.g., need help shaving, reminders to brush teeth)	<input type="checkbox"/>	<input type="checkbox"/>	Falling down	<input type="checkbox"/>	<input type="checkbox"/>
			Feeling dizzy or lightheaded	<input type="checkbox"/>	<input type="checkbox"/>
			Trouble with or change in your walking	<input type="checkbox"/>	<input type="checkbox"/>

Are there any other changes or problems with your thinking? Please describe:

Are any of the difficulties described above interfering with your ability to carry out daily activities at home, work, school, or socially? Please explain:

Are there any current or ongoing stressors in your life (e.g., work, marital/partner stress, problems with coworkers, family member's poor health, problems with grown children)? Please explain:

Trauma can come in many forms and affects individuals differently. For the purpose of understanding your experiences and providing the best support, we're interested in learning about any past events that have been particularly distressing or challenging for you. Below is a list of experiences that might qualify as traumatic.

This list is not exhaustive but serves as a guide. Please share any experiences that you feel comfortable discussing, keeping in mind that you can skip any question that makes you feel uncomfortable.

- Directly experiencing a serious injury, sexual violence, or a life-threatening event
- Witnessing, in person, an event where others were seriously injured, killed, or subjected to sexual violence
- Learning that a violent or accidental event occurred to a close family member or close friend
- Experiencing repeated or extreme exposure to aversive details of traumatic events (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse)

Please describe any events you are comfortable sharing, including when they happened, how they impacted you at the time, and whether they continue to affect you. Remember, there is no right or wrong answer; your experiences are valid.

Psychiatric/Emotional History

For each item below, place a mark in the “Past” box if this was a problem for you in the past, and place a mark in the “Current” box if it is currently a problem for you (you can mark both “Past” and “Current” if necessary):

	Past	Current		Past	Current
Hearing things or seeing things that other people don't	<input type="checkbox"/>	<input type="checkbox"/>	Social anxiety (e.g., talking in public, eating in front of other people)	<input type="checkbox"/>	<input type="checkbox"/>
Hoarding	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained inability to move parts of your body	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or excessive worry	<input type="checkbox"/>	<input type="checkbox"/>
Racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive thoughts or compulsive behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Pressured Speech/More talkative than usual	<input type="checkbox"/>	<input type="checkbox"/>	Pulling out hair or eyelashes, or skin-picking	<input type="checkbox"/>	<input type="checkbox"/>
Decreased or absent need for sleep	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to a life-threatening event (e.g., war, rape, physical assault)	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or extreme mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Problems with temper or “rage attacks”	<input type="checkbox"/>	<input type="checkbox"/>	Flashbacks	<input type="checkbox"/>	<input type="checkbox"/>
Depression (e.g., sadness, increased crying, feeling “blue”)	<input type="checkbox"/>	<input type="checkbox"/>	Feeling detached from your body (“out-of-body experience”)	<input type="checkbox"/>	<input type="checkbox"/>
Extreme fears or phobias	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder (e.g., anorexia, bulimia, binge-eating)	<input type="checkbox"/>	<input type="checkbox"/>

How would you describe your current mood (e.g., happy, sad, angry, nervous)? _____

Have you ever been hospitalized for emotional/psychiatric difficulties? ☐ No ☐ Yes

Have you ever received outpatient treatment for emotional or psychiatric problems (e.g., school counselor, psychotherapy, marriage counseling, etc.)? ☐ No ☐ Yes

IF YES → Are you currently in counseling? ☐ No ☐ Yes

Do you have a history of physical, sexual or emotional abuse (including domestic violence)? ☐ No ☐ Yes

Has anyone ever pressured you or influenced you to give/transfer funds, real estate, or your personal property to them? ☐ No ☐ Yes

Have you ever taken medication for psychiatric problems? ☐ No ☐ Yes

IF YES → Please list medication name, dose and note if past or current:

Have you ever thought about or attempted suicide? ☐ No ☐ Yes

IF YES → Are you currently having any suicidal thoughts or behaviors? ☐ No ☐ Yes

Do you feel safe in your home? ☐ No ☐ Yes

Developmental History

Were you born: ☐ On time ☐ Early (how early? _____) ☐ Late (how late? _____)

What was your weight at birth? _____

Were there any complications during your mother's pregnancy or delivery with you?

IF YES →

☐ Gestational diabetes

☐ High blood pressure

☐ High fever

☐ Injuries/accidents

☐ Other: (please describe) _____

While she was pregnant with you, did your mother use: ☐ alcohol ☐ cigarettes ☐ drugs ☐ n/a

To the best of your knowledge, were you delayed in any of the following areas?

☐ Walking

☐ Talking

☐ Toilet training

Please list any serious injuries, infections, or surgeries you had as a child (e.g., seizures, measles, mumps, rheumatic fever).

As a child or teenager, did you have any of the following? Please mark all that are applicable:

Academic learning problems	<input type="checkbox"/>	Poor listening skills	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	Poor concentration or short attention span	<input type="checkbox"/>
Problems with walking or handwriting	<input type="checkbox"/>	Poor organization	<input type="checkbox"/>
Bed wetting	<input type="checkbox"/>	Distractibility	<input type="checkbox"/>
Poor peer relations	<input type="checkbox"/>	Poor judgment	<input type="checkbox"/>
Repetitive behaviors/tics	<input type="checkbox"/>	Poor temper or impulse control	<input type="checkbox"/>
Anxiety/fears	<input type="checkbox"/>	Poor frustration tolerance	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Excessive fighting	<input type="checkbox"/>
Suicidal ideation	<input type="checkbox"/>	Alcohol/drug abuse	<input type="checkbox"/>
Self-harm/cutting	<input type="checkbox"/>	Running away	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	Difficulties with the law	<input type="checkbox"/>
Unusual beliefs/delusions	<input type="checkbox"/>	Fire setting	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	Truancy	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	Cruelty to animals	<input type="checkbox"/>
Bullying others	<input type="checkbox"/>	Property destruction	<input type="checkbox"/>

Academic, Employment, & Social History

Please indicate the highest level of education you have completed:

- ☐ 6th – 8th grade
- ☐ 9th – 11th grade
- ☐ 12th grade/high school diploma
- ☐ GED
- ☐ Some college: 1 year
- ☐ Some college: 2-3 years
- ☐ Associate's Degree (please specify major/concentration: _____)
- ☐ Bachelor's Degree (please specify major: _____)
- ☐ Master's Degree (please specify concentration: _____)
- ☐ Doctoral Degree (e.g., MD, PhD, JD – please specify: _____)

Did you receive any special education services, resource room services, or tutoring services in school?

- ☐ Yes ☐ No

Did you ever have to repeat a grade? ☐ No ☐ Yes (Please specify which grade(s): _____)

Did you ever skip a grade? ☐ No ☐ Yes (Please specify which grade(s): _____)

Did you have trouble learning to read? ☐ No ☐ Yes

Did you have trouble learning basic math? ☐ No ☐ Yes

Are you currently employed? ☐ No ☐ Yes

IF YES → Where do you work? _____

What is your job title? _____

How long have you been at this job? _____

How many hours per week do you work? _____

IF NO → Have you been employed in the past? _____

If so, where did you work and what was your title? _____

How long did you work at that job? _____

When was the last date you were employed? _____

Have you ever been arrested? ☐ No ☐ Yes

Do you currently have any legal problems (parole, probation, etc.)? ☐ No ☐ Yes

Do you have any lawsuits pending or do you intend to sue in the near future? ☐ No ☐ Yes

Medical History

Please check all the following that apply to you:

Who is your General Practitioner? _____

Do you have any Medical Specialist you currently see? _____

	Past	Current		Past	Current
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Metabolic Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	TIA (“mini-stroke”)	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Toxic Exposure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary (Lung) disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis/Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

Do you currently smoke cigarettes? ☐ No ➔ Have you ever smoked cigarettes in the past? ☐ No ☐ Yes

☐ Yes ➔ On average, how many cigarettes do you smoke per day? _____

How long have you smoked? _____

Have you ever used recreational drugs? ☐ No ☐ Yes

If yes ➔ Please check all the following that apply to you, either past or current (or both if applicable):

	Past	Current		Past	Current
Marijuana or Spice	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (including crack cocaine)	<input type="checkbox"/>	<input type="checkbox"/>	PCP	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine/Crystal Meth	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant (e.g., “huffing”)	<input type="checkbox"/>	<input type="checkbox"/>
Other hallucinogen (e.g., LSD, acid, psilocybin/mushrooms, peyote)	<input type="checkbox"/>	<input type="checkbox"/>	Prescription pain medications (not as prescribed)	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe):				<input type="checkbox"/>	<input type="checkbox"/>

Do you currently drink alcohol? ☐ No ☐ Yes

If yes, on average, how many drinks do you have per week? _____

Have you ever had periods of heavy alcohol use in the past? ☐ No ☐ Yes

Medical History (continued)

Have you ever had a head injury: ☐ No ☐ Yes

If yes → Please list date(s): _____

After the head injury, did you experience any of the following?

- ☐ Loss of consciousness (if yes, how long? _____)
- ☐ Blurred vision/double vision
- ☐ Dizziness
- ☐ Nausea
- ☐ Vomiting
- ☐ Headaches
- ☐ Changes in taste or smell

Did you seek medical treatment? ☐ No ☐ Yes

Were you admitted to a hospital? ☐ No ☐ Yes

If yes, how long? _____

Did you have a head CT or MRI scan?

What medications do you currently take? Please list dose if known.

Have you ever received psychological, neuropsychological, or cognitive testing? ☐ No ☐ Yes

If yes, please list: Date(s) _____

Doctor: _____

Facility or location: _____

Have you ever received: Physical therapy: ☐ No ☐ Yes

Occupational therapy: ☐ No ☐ Yes

Speech therapy ☐ No ☐ Yes

Have you ever had surgery (please list)? _____

Medical History (continued)

Do you have any trouble sleeping? ☐ No ☐ Yes

If yes ➔ Is it hard for you to fall asleep? ☐ No ☐ Yes

Is it hard for you to stay asleep? ☐ No ☐ Yes

What time do you usually go to bed? _____

What time do you usually wake up? _____

Do you take any medications or supplements to help you sleep? ☐ No ☐ Yes

If yes, please list: _____

Are you tired during the day or do you take naps? ☐ No ☐ Yes

Do you snore? ☐ No ☐ Yes

Do you have sleep apnea? ☐ No ☐ Yes

IF YES ➔ Do you use a CPAP or BiPAP machine? ☐ No ☐ Yes

Do you ever stop breathing or wake up gasping for air when asleep? ☐ No ☐ Yes

Do you have frequent vivid dreams or nightmares? ☐ No ☐ Yes

Are you a restless sleeper or do you have restless leg syndrome? ☐ No ☐ Yes

Do you experience chronic pain? ☐ No ☐ Yes

IF YES ➔ Where is the pain located in your body? _____

Are you in any pain right now? ☐ No ☐ Yes

IF YES ➔ Where is the pain located in your body? _____

Have you tried any pain treatments (e.g., massage, acupressure/acupuncture, medications)? ☐ No ☐ Yes

If yes, how helpful have the treatments been? _____

FAMILY HISTORY

Please indicate whether **any members of YOUR biological family (blood relatives only – do not include stepfamily or people related to you by marriage)** had any of the following (including children, brothers, sisters, parents, grandparents, aunts, uncles, cousins):

Alzheimer's disease or other dementia	<input type="checkbox"/>	Schizophrenia/Schizoaffective Disorder	<input type="checkbox"/>
Anxiety disorder (e.g., panic attacks, phobias)	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>
Bipolar Disorder (Manic Depression)	<input type="checkbox"/>	Attention-Deficit/Hyperactivity Disorder	<input type="checkbox"/>
Major Depression	<input type="checkbox"/>	Seizure Disorder (Epilepsy)	<input type="checkbox"/>
Learning Disabilities	<input type="checkbox"/>	Stroke or TIA ("mini-stroke")	<input type="checkbox"/>
Memory Problems	<input type="checkbox"/>	Alcohol or drug abuse/dependence	<input type="checkbox"/>
Intellectual Disability (mental retardation)	<input type="checkbox"/>	Suicide	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Huntington's disease	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Psychiatric Hospitalization	<input type="checkbox"/>	Other:	<input type="checkbox"/>

Is there anything else that you would like to add?

Name and phone number of emergency contact:

Relationship:

Preferred Email:
