Solara Psychological

2525 Kell E Blvd #405
Wichita Falls, TX 76308
Voice: 940-249-0081
Email: testing @solarapsych.com

Dr. Arthur R. Cardona
Clinical Psychologist

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

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	☐	☐	Social anxiety (e.g., talking in public, eating in front of other people)	☐	☐
Hoarding	☐	☐	Panic attacks	☐	☐
Unexplained inability to move parts of your body	☐	☐	Frequent or excessive worry	☐	☐
Racing thoughts	☐	☐	Obsessive thoughts or compulsive behaviors	☐	☐
Pressured Speech/More talkative than usual	☐	☐	Pulling out hair or eyelashes, or skin-picking	☐	☐
Decreased or absent need for sleep	☐	☐	Exposure to a life-threatening event (e.g., war, rape, physical assault)	☐	☐
Frequent or extreme mood swings	☐	☐	Frequent nightmares	☐	☐
Problems with temper or "rage attacks"	☐	☐	Flashbacks	☐	☐
Depression (e.g., sadness, increased crying, feeling "blue")	☐	☐	Feeling detached from your body ("out-of-body experience")	☐	☐
Extreme fears or phobias	☐	☐	Eating Disorder (e.g., anorexia, bulimia, binge-eating)	☐	☐

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

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	☐	☐	Metabolic Disorders	☐	☐
Brain Tumor	☐	☐	Multiple Sclerosis	☐	☐
Cancer	☐	☐	Obesity	☐	☐
Heart disease or heart attack	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	TIA ("mini-stroke")	☐	☐
Headaches	☐	☐	Seizure	☐	☐
High Blood Pressure	☐	☐	Toxic Exposure	☐	☐
High Cholesterol	☐	☐	Thyroid Problem	☐	☐
Kidney Disease	☐	☐	HIV/AIDS	☐	☐
Lupus	☐	☐	Pulmonary (Lung) disease	☐	☐
Liver Disease	☐	☐	Other:	☐	☐
Meningitis/Encephalitis	☐	☐	Other:	☐	☐

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	☐	☐	Heroin	☐	☐
Cocaine (including crack cocaine)	☐	☐	PCP	☐	☐
Methamphetamine/Crystal Meth	☐	☐	Inhalant (e.g., "huffing")	☐	☐
Other hallucinogen (e.g., LSD, acid, psilocybin/mushrooms, peyote)	☐	☐	Prescription pain medications (not as prescribed)	☐	☐
Other (please describe):				☐	☐

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

Is there anything else that you would like to add?

_____

_____

_____

_____

_____

_____

Name and phone number of emergency contact: Relationship:

_____

Preferred Email:

_____

Digital Signature: