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HISTORY FORM

Thank you for taking the time to complete this form. This information is essential for me to conduct a thorough evaluation.

CLIENT'S FULL NAME: _____ Date of Birth _____

Address: _____

_____

Phone: Home:_____Cell:_____Work:_____

E-mail: _____

Please provide information for **a living parent who can be interviewed** for this evaluation:

Name: _____ Relationship to you: _____

Address (if different from above): _____

_____

Phone: Home:_____Cell:_____Work:_____

E-mail: _____

Developmental History

1. Did your mother take any medications during her pregnancy with you, or did she have any difficulties during her pregnancy with you requiring medication and/or bed rest?

2. Did your mother take any illicit drugs or alcohol or tobacco during her pregnancy with you?

3. Did you have any early developmental problems, in the first 3 years? Speech delay, late to walk, etc.

4. Did you have any medical (chronic illnesses such as asthma and diabetes) or developmental problems (delays in motor skills, social skills, communication, etc.) **during your childhood**?

Medical and Psychiatric History

Current Primary Care Physician: _____

Address: _____ Phone: _____

Have you had any health problems **in adulthood** (e.g., asthma, diabetes, heart disease, cancer)?

_____

_____

Are you taking any type of medication currently?

Name of medication	Dosage	Reason	Date begun

Have you taken any medications in the past?

Name of medication	Dosage	Reason	Dates

Are you working with any health professionals **currently**, including therapists, psychologists, or psychiatrists?

Provider	Phone	Date Begun	Reason for seeing them

Have you worked with any health professionals **in the past**, including therapists, psychologists, or psychiatrists?

Provider	Phone	Date Begun	Reason for seeing them

General Information

	You	Your Spouse/Partner
Name		
Education level		
Occupation		
Age		
Religion		

Do you have any siblings?

Name_____ M / F Full/Step/Half Age _____
Name_____ M / F Full/Step/Half Age _____
Name_____ M / F Full/Step/Half Age _____

If you have children, please provide their names and ages:

Name_____ M / F Bio/Adopted/Step Age _____
Name_____ M / F Bio/Adopted/Step Age _____
Name_____ M / F Bio/Adopted/Step Age _____

School History

Highest level of school completed: _____

Did you ever have extra help in school (K-12) or receive specialized education services?

Did you experience any of the following in your education history?

- ❑ IEP/504 plan
- ❑ Held back 1 or more grades
- ❑ Skipped 1 or more grades
- ❑ Learning problems
- ❑ Oppositional behavior
- ❑ Attention problems
- ❑ Hyperactivity problems
- ❑ Underachieving
- ❑ Difficulties with schoolwork/homework

Family History

Do any of your ***biological*** relatives have any of the following conditions? Please check all that apply, past or present.

	MOTHER	FATHER	MOTHER'S FAMILY	FATHER'S FAMILY	YOUR SIBLINGS
Intellectual Disability (i.e., MR)					
Epilepsy					
Social Awkwardness or Autism					
Learning Problems					
Attention Problems					
Hyperactivity					
Problems with Anger					
Alcohol/Drug Abuse					
Depression					
Suicide Attempt					
Anxiety					
Obsessive-Compulsive Disorder					
Bipolar Disorder					
Schizophrenia					
Psychosis					
Criminal History					
Psychiatric Hospitalization					

Your Goals

Please briefly describe current **concerns** and **goals** you have for this evaluation/therapy: _____

_____

_____

_____

_____

Please briefly describe your **strengths** and things you have in your life currently that provide you with a sense of well being and contentment: _____

_____

_____

_____

_____