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ADULT 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 _____

Preferred pronouns: ❑she/her ❑he/him ❑they/them

Gender: ❑ Male ❑ Female ❑ Transgender Female ❑ Transgender Male ❑ Non-Binary ❑ Genderqueer

Address: _____

_____

Phone: Home:_____Cell:_____Work:_____

E-mail: _____

This form completed on (date): _____

Referred by: _____

Please provide information for **A LIVING PARENT (if parents are deceased a spouse or sibling is acceptable) 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. Did she have any difficulties during the pregnancy requiring medication or bed rest? Any labor and delivery complications?

2. Did your mother take any 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	YOUR CHILDREN
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: _____

_____

_____

_____

_____

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

_____

_____

_____