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ADULT HISTORY FORM

The following questions will provide information to help us conduct your evaluation. Please answer them as accurately and completely as possible. We will review this information with you, and you will have a chance to discuss your answers in detail. Thank you for your kind cooperation.

Name of person filling out this form (if not patient)_____

Patient name _____ Date _____

Have you had a neuropsychological evaluation within the past six months? Yes ☐ No ☐ If yes, when and with whom_____
_____

In school: Did you ever repeat a grade? Yes ☐ No ☐
If yes, which grade(s) _____

Were you ever placed in special classes? Yes ☐ No ☐
If yes, what kind of classes and in which grades: _____
Did you ever receive any other type of special services in school? Yes ☐ No ☐
If yes, what kind of services and in which grades: _____

	Name of school	Year graduated	Degree	Major
High school				
2 yr College				
University				
Post graduate study				
Post graduate study				

At work: are you employed outside the home? Yes ☐ No ☐
If yes, what is your occupation? _____ How many hours per week do you work? _____
If no, are you unable to work because of an injury or illness? Yes ☐ No ☐
Last date worked: _____ If you are not working now, what was your former occupation? _____

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Are you Right handed? ☐ Left handed? ☐ Ambidextrous? ☐

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Please check the box if you have had any of the following illnesses or conditions.

AIDS/HIV positive	☐	Chronic fatigue syndrome	☐
Arthritis	☐	Concussion/ head injury	☐
Asthma/bronchitis	☐	Diabetes	☐
Broken bones/fractures	☐	Epilepsy/seizure	☐
Cancer	☐	Exposure to toxins (such as lead, mercury, solvents)	☐

Fibromyalgia	☐	Meningitis	☐
GERD	☐	Migraines	☐
Heart disease	☐	Multiple Sclerosis	☐
High blood pressure	☐	Parkinson's disease	☐
Hypoglycemia	☐	Polio	☐
Irritable Bowel syndrome	☐	Stroke	☐
Kidney disease	☐	Thyroid disease	☐
Liver disease	☐	Tumor	☐
Lung disease	☐	Ulcer	☐
Lupus	☐		

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Please list any surgeries you have had (Procedures and dates): _____
_____
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_____
_____
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Have you experienced any of the following?

Formal diagnosis of emotional or psychiatric problems	Yes ☐ No ☐
Treatment by a psychiatrist, psychologist, or psychotherapist	Yes ☐ No ☐
Hospitalization for emotional or psychiatric problems	Yes ☐ No ☐
Taken medication for emotional or psychiatric problems	Yes ☐ No ☐
Treated with ECT (electroconvulsive or “shock” therapy)	Yes ☐ No ☐

If you answered "yes" to any of the above, please explain _____
_____
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Have you noticed any problems in your sense of

vision	Yes ☐ No ☐
hearing	Yes ☐ No ☐
smell	Yes ☐ No ☐
taste	Yes ☐ No ☐
touch	Yes ☐ No ☐

Are you having any problems with

alertness	Yes ☐ No ☐
anger	Yes ☐ No ☐
appetite	Yes ☐ No ☐
balancing checkbook	Yes ☐ No ☐
concentration	Yes ☐ No ☐
coordination	Yes ☐ No ☐
dizziness	Yes ☐ No ☐
driving	Yes ☐ No ☐
energy	Yes ☐ No ☐
fainting	Yes ☐ No ☐
headaches	Yes ☐ No ☐

Are you having any problems with

irritability	Yes ☐ No ☐
memory	Yes ☐ No ☐
numbness	Yes ☐ No ☐
pain	Yes ☐ No ☐
reading	Yes ☐ No ☐
sadness	Yes ☐ No ☐
sense of direction	Yes ☐ No ☐
sleep	Yes ☐ No ☐
speech	Yes ☐ No ☐
balance in walking	Yes ☐ No ☐
weakness	Yes ☐ No ☐
writing	Yes ☐ No ☐

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Do you smoke? Yes ☐ No ☐ If yes, how much _____
Have you quit smoking? Yes ☐ No ☐ If yes, when did you stop? _____ How much did you used to smoke? _____
How much alcohol do you drink? _____
Have you ever been arrested for DUI/DWI? Yes ☐ No ☐ If yes, when?
Have you ever been treated for problems related to alcohol use? Yes ☐ No ☐ If yes, when?_____
Have you ever attended a meeting of Alcoholics Anonymous? Yes ☐ No ☐
Have you ever used street drugs (including marijuana) regularly? Yes ☐ No ☐ If yes, which ones? _____

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What medicines (including vitamins) are you taking

now?_____
_____
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_____
_____
_____
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Please list **all** of the doctors, therapists, and other providers treating you right now.

Name	Specialty

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Please rate the amount of stress you are currently experiencing

	Little or none						Extreme	
At home:	1	2	3	4	5	6	7	NA
At work:	1	2	3	4	5	6	7	NA
With extended family:	1	2	3	4	5	6	7	NA
With friends:	1	2	3	4	5	6	7	NA
With neighbors:	1	2	3	4	5	6	7	NA