CENTER FOR PSYCHOLOGY AND COUNSELING
118 E. Sunbridge Dr.
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PATIENT HISTORY – ADULT FORM

This form is for the PATIENT'S childhood history. All questions are about you, not about your children. Please complete this form to the best of your ability.

Patient's Name: _____ Birth Date: _____ Age: _____ Sex: _____

Who referred you to this clinic? _____

FAMILY INFORMATION:

Father's name: _____ Birth Date: _____
Occupation: _____ Employer: _____
Highest School Grade Completed: _____ Other training: _____
Religion: _____

Mother's Name: _____ Birth Date: _____
Occupation: _____ Employer: _____
Highest School Grade Completed: _____ Other training: _____
Religion: _____

Marital Status of parents: _____ Marriage Date: _____
Date divorced, if applicable: _____ Death of parent, if applicable: _____

Who do you live with: Alone ☐ Spouse/Partner ☐ Roommates ☐
Other: _____

How long have you lived at the current address? _____

Where else have you lived during your life? _____

List all persons living in the home:

NAME	AGE	RELATIONSHIP TO PATIENT

PRESENTING CONCERNS:

What do you think is your main problem? How long have you been having this problem?

What do you believe caused your problem?

What have you been told by doctors, teachers and / or others about your problem?

Do you have concerns about other family members? ☐ Y ☐ N (if yes, please explain)

What do you expect or hope to have happen as a result of an evaluation?

Persons with developmental problems often act younger than they are. What age level do you think best describes your current behavior?

PATIENT'S BIRTH HISTORY:

Was the pregnancy planned? ☐ Y ☐ N Medical care began in the _____month of pregnancy
☐ Routine ☐ Sporadic

Birth was: ☐ Normal ☐ Caesarean ☐ Breech ☐ Twins or more Birth weight: _____

Were there any complications? ☐ Y ☐ N (if yes, please explain)

How many **hours of sleep** do you get per night? _____

Complete the following table for all of your mother's pregnancies in chronological order including any miscarriages or stillbirths. (Write on the back if additional space is needed.)

Name	DOB	Birth Weight	Length of Pregnancy	Length of Labor	Problems of birth	Any physical, emotional, behavioral, or education problems?

Has your mother or father had any serious illness in the past? ☐ Y ☐ N (if yes, please explain)

What stressors have impacted your family recently? (i.e., deaths, marital conflicts, financial worries, etc.)

Please note below if any of your relatives have had any of the following conditions. (For example: brother, parent, grandparent, aunt, cousin)

	Relationship to patient
School Difficulties	_____
Over activity, Attention problems	_____
Mental Illness	_____
Speech Problems	_____
Emotional Problems	_____

CHILDHOOD GROWTH AND DEVELOPMENT:

Motor Skills: Did you have any motor delay? ☐ Y ☐ N (if yes, please explain)

_____

Language and Hearing: Did you have any language/hearing delay? ☐ Y ☐ N (if yes, please explain)

_____

Feeding: Did you have any problems with feeding? ☐ Y ☐ N (if yes, please explain)

_____

Personal: At what age were you bladder trained? _____ Bowel trained? _____

Social: Do you have any concerns about your social development? ☐ Y ☐ N (if yes, please explain)

_____

MEDICAL HISTORY:

Have you ever been hospitalized? ☐ Y ☐ N If yes, why_____

Are you **CURRENTLY** taking any medications? ☐ YES ☐ NO

Please list any medications and dosages that you currently take:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any **allergies to medications**? If so please list

Have you ever had a serious illness or accident? ☐ Y ☐ N (if yes, please explain)

Do you have a history of any of the following:

Heart disease ☐	Headaches ☐	Seizures ☐
Glaucoma ☐	Liver Disease ☐	Hallucinations ☐

If yes, please describe, indicating age, and complications:

BEHAVIOR:

Are you having any problems with your behavior? ☐ Y ☐ N (if yes, please explain)

Are you having any legal issues? ☐ Y ☐ N (if yes, please explain)

Do you ever use any illegal drugs or substances? ☐ Y ☐ N (if yes, please explain)

How many weekends out of 4 do you “drink more than you should”?

SCHOOL HISTORY:

Please complete the following about yourself, beginning with nursery/day care and ending with current placement. (If need more room, use other side of this page)

School	Address	Grade or class placement	Dates of Attendance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list the names and addresses of other professionals who have worked with you and your family.

NAME COMPLETE ADDRESS

Physician _____

Psychologist/Counselor_____

Other (please specify) _____

Please use this space for any other information you feel will be helpful to us in your evaluation.