COMPREHENSIVE ADULT HISTORY FORM

Developed by:

Ray W. Christner, Psy.D., NCSP

Patient's Name: ______________________________ Date of Birth: ______________

Ethnicity/Cultural Identification: ________________ Gender: __________ Age: ________

Person Completing this Form (If other than Patient): ______________________________

General Instructions

Dear Patient:

As part of our work with you, we ask that you fill out this form as fully and openly as possible. This information is helpful to ensure an accurate assessment, which will assist us in making appropriate diagnostic decisions and recommendations. You may add or attach any additional information that you feel would be helpful in the evaluation process (e.g., past psychological reports, etc.). We appreciate your cooperation and willingness to complete this form and to return it promptly to our office. When completing the form, consider the following instructions:

1. Please read the questions carefully and answer them in full.

2. Write as legibly as possible.

3. The patient or a legal guardian should complete all forms.

4. Please understand this information is for evaluation, intervention, and recommendation purposes. The information you provide will be part of the evaluation. If there are specific details that you are hesitant in sharing, please contact our office for clarification or bring these issues to our attention during your appointment.

Thank you in advance for completing this form.

Cognitive Health *Solutions* LLC

Copyright ©2011 Cognitive Health Solutions, LLC. All rights reserved. Photocopying this form is prohibited without prior written consent.

REFERRAL INFORMATION

Describe your main concern or problems (include details and dates when problems began).

____

____

____

Describe what you see as the cause of these difficulties.

____

____

Describe any services or interventions you would like to receive.

____

____

____

Describe your strengths.

____

____

FAMILY INFORMATION

Check all of the following that best describe your current living situation.

☐ Alone ☐ With Spouse/Family ☐ With Significant Other
☐ With Parents/Family ☐ Apartment ☐ House
☐ Homeless ☐ Shelter ☐ Other: ___________________

List the names and information requested for all individuals living in the household (include significant others, caregivers, children, etc.).

Name	*Age*	*Relationship*	*Comments/Concerns*

Do you have children living outside your home? ☐ Yes ☐ No

If yes, list names, ages, and describe relationship: ______________________________

____

What is the primary language spoken at home? ______________________________

Does the family speak a second language? ☐ Yes ☐ No Language: ________________

If yes, circle proficiency: ☐ Fluent ☐ Limited ☐ Other

Check if there is a family history of any of the conditions or problems noted below.

Condition/Concern	*Mother*	*Father*	*Siblings*	*Other Relatives*
Learning or School-Related Problems				
Developmental Disability (e.g., MR, ASD)				
Attention Problems				
Behavior Problems				
Emotional Problems/Mental Health				
Substance Abuse/Addiction				
Medical Problems				

Provide explanation of any items checked above:

____

____

____

List any agencies and/or caseworkers currently working with you or your family (i.e., OVR, MH/MR, etc.).

____

____

____

Describe any major stresses that have occurred in the family that may be affecting you (e.g., death of family member, divorce, etc.).

____

____

____

____

DEVELOPMENTAL AND EARLY HISTORY

Please answer this section to the best of your knowledge.

Were there any problems with your mother's pregnancy with you? ☐ Yes ☐ No

Check any of the following health complications that occurred during the pregnancy.

☐ Fever	☐ Vaginal bleeding	☐ Toxemia
☐ High blood pressure	☐ Gestational diabetes	☐ Trauma/injury
☐ Rash	☐ Emotional problems	☐ Abnormal weight gain
☐ Anemia	☐ Excessive swelling	☐ Excessive vomiting
☐ Blood incompatibility	☐ Preeclampsia	☐ Other:

Provide explanation of any items checked above: ____________________

____

____

Check any of the following used by the mother during the pregnancy.

☐ Prescription medication: (*list name and dose)* ____________________

☐ Over-the-counter medications: (*list name and dose)* ____________________

☐ Illegal substances: (*list name and amount)* ____________________

☐ Alcoholic beverages: (*list type and amount)* ____________________

☐ Cigarettes: *Number of cigarettes per day:* ________

Provide further information regarding pregnancy, as needed.

____

____

____

____

What was the length of pregnancy? ________ weeks

Was the labor and delivery normal? ☐ Yes ☐ No

If no, explain: ____________________

____

____

____

What was your birth weight? __________ Pounds __________ Ounces

The delivery was: ☐ Vaginal ☐ Cesarean (reason): ______________________________

Check any of the following complications that occurred during the delivery.

☐ Breech birth	☐ Cord around neck	☐ Meconium staining
☐ Lack of oxygen (turned blue)	☐ Forceps used	☐ Suction used
☐ Labor induced	☐ Medication for labor	☐ Cardiopulmonary distress
☐ Seizures	☐ Other:	☐ Other:

Provide explanation of any items checked above: ______________________________

____

____

____

What was your overall rate of development: ☐ Early ☐ Average ☐ Late

Indicate your development by checking one description in each area.

Crawling	☐ Early	☐ Average	☐ Late
Walking alone	☐ Earl	☐ Average	☐ Late
Riding a bike	☐ Early	☐ Average	☐ Late
First words	☐ Early	☐ Average	☐ Late
Talking in sentences	☐ Early	☐ Average	☐ Late
Toilet-trained day	☐ Early	☐ Average	☐ Late
Toilet-trained night	☐ Early	☐ Average	☐ Late

Please indicate if there were developmental concerns in of the following areas:

☐ Motor skills (describe): ______________________________

☐ Oral motor skills (e.g., drooling, etc.) (describe): ______________________________

☐ Speech/Language skills (describe): ______________________________

☐ Bedwetting (until what age?): ______________________________

☐ Urine accidents (until what age?): ______________________________

☐ Soiling accidents (until what age?): ______________________________

MEDICAL AND MENTAL HEALTH INFORMATION

How is your overall health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

List any serious illnesses, accidents, injuries, hospitalizations, or surgeries.

Incident	*Date(s)*	*Provide Details*

Has your vision been checked? ☐ Yes ☐ No Any problems? ___________________

Has your hearing been checked? ☐ Yes ☐ No Any problems? ___________________

Date of last physical examination: _______________ By Whom: ___________________________________

Check any current or past concerns, provide a brief description.

Condition	*Occurrence*			*Provide Details for Each Checked*
Allergies	☐ Past	☐ Current	☐ Never	
Asthma	☐ Past	☐ Current	☐ Never	
Diabetes	☐ Past	☐ Current	☐ Never	
Seizures/Convulsions	☐ Past	☐ Current	☐ Never	
Failure to thrive	☐ Past	☐ Current	☐ Never	
Loss of consciousness	☐ Past	☐ Current	☐ Never	
High fevers	☐ Past	☐ Current	☐ Never	
Motor or vocal tics	☐ Past	☐ Current	☐ Never	
Lead poisoning	☐ Past	☐ Current	☐ Never	
Dizziness/blurred vision	☐ Past	☐ Current	☐ Never	
Stomach pain	☐ Past	☐ Current	☐ Never	
Urination problems	☐ Past	☐ Current	☐ Never	
Constipation	☐ Past	☐ Current	☐ Never	
Frequent ear infections	☐ Past	☐ Current	☐ Never	
Ear tubes placed	☐ Past	☐ Current	☐ Never	
Staring spells	☐ Past	☐ Current	☐ Never	
Sleep problems	☐ Past	☐ Current	☐ Never	
Frequent headaches	☐ Past	☐ Current	☐ Never	

Meningitis	☐ Past	☐ Current	☐ Never	
Encephalitis	☐ Past	☐ Current	☐ Never	
Epilepsy	☐ Past	☐ Current	☐ Never	
Exposure to toxin	☐ Past	☐ Current	☐ Never	
Head banging	☐ Past	☐ Current	☐ Never	
Temper tantrums	☐ Past	☐ Current	☐ Never	
Excessive vomiting	☐ Past	☐ Current	☐ Never	
Eating problems	☐ Past	☐ Current	☐ Never	
Self-injurious behavior	☐ Past	☐ Current	☐ Never	
Repetitive movements	☐ Past	☐ Current	☐ Never	
Impulsivity	☐ Past	☐ Current	☐ Never	
Clumsiness/Accident prone	☐ Past	☐ Current	☐ Never	
Rocks back and forth	☐ Past	☐ Current	☐ Never	
Under-eating	☐ Past	☐ Current	☐ Never	
Overeating	☐ Past	☐ Current	☐ Never	
Eating nonfood items	☐ Past	☐ Current	☐ Never	
Other: ___________________	☐ Past	☐ Current	☐ Never	
Other: ___________________	☐ Past	☐ Current	☐ Never	

Describe any head injuries (e.g., loss of consciousness, stroke, skull fractures, etc.), including dates, treating providers, and outcomes.

____

____

List any medications you take on a regular basis:

Medication	*Dosage/Frequency*	*Reason*	*Side Effects*

List any mental health/behavioral treatment received (e.g., inpatient, outpatient, substance, etc.):

Dates of Service	*Provider*	*Reason*	*Outcome*

Check any of the following that you have received.

- ☐ Inpatient hospitalization
- ☐ Partial Hospitalization
- ☐ Outpatient services
- ☐ Wraparound services
- ☐ Family-based mental health
- ☐ Residential treatment facility
- ☐ Drug and alcohol treatment
- ☐ MH/MR case management
- ☐ Medication management
- ☐ AA/NA attendance
- ☐ Other:
- ☐ Other:

SUBSTANCE USE/ABUSE INFORMATION

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, what is the frequency of your drinking? ☐ 1-2 days/wk ☐ 3-6 days/wk ☐ daily ☐ binge

Provide information on any concerns regarding your alcohol use.

____

____

____

____

Check any drugs that you are using *now* or have used *in the past*, and describe how the drug usage (amount, frequency, and method of administration).

			Amount, Frequency, and Method of Administration
Methamphetamine	☐ Now	☐ In Past	____________
Other amphetamines	☐ Now	☐ In Past	____________
Cocaine or crack	☐ Now	☐ In Past	____________
LSD	☐ Now	☐ In Past	____________
Other hallucinogens	☐ Now	☐ In Past	____________

Benzodiazepines ☐ Now ☐ In Past ____________________

Cannabis/Marijuana ☐ Now ☐ In Past ____________________

Heroin ☐ Now ☐ In Past ____________________

Other opioids ☐ Now ☐ In Past ____________________

PCP ☐ Now ☐ In Past ____________________

Nicotine ☐ Now ☐ In Past ____________________

Caffeine ☐ Now ☐ In Past ____________________

Other (specify): ☐ Now ☐ In Past ____________________

EDUCATIONAL INFORMATION

List all schools this child has attended (include preschool).

School	*Location*	*Grade(s)*	*Comments/Problems*

Did you ever repeat or skip a grade? ☐ Yes ☐ No

If yes, indicate which grade and reasons: ____________________

____

Were you ever evaluated for special education services in school? ☐ Yes ☐ No

If yes, indicate the results: ____________________

____

____

Did you ever receive special services in school? ☐ Yes ☐ No

If yes, please describe: ____________________

____

____

____

Describe your academic and/or behavioral strengths when in school:

____
____
____
____

Describe your academic and/or behavioral weaknesses or needs when in school:

____
____
____

Do you believe you made normal progress in school? ☐ Yes ☐ No

Please provide any additional information regarding your educational or school background:

____
____
____
____

SOCIAL INTERACTIONS

Did you have problems getting along with other children when you were a child? ☐ Yes ☐ No

Do you have difficulty making and keeping friends? ☐ Yes ☐ No

Do you find being in a social situation difficult? ☐ Yes ☐ No

If you checked yes for any of the above questions, describe your response.

____
____
____
____
____

LEGAL HISTORY

Were you ever arrested or had legal charges filed against you? ☐ Yes ☐ No

If yes, explain: ______________________________

____

____

____

Are you currently on probation or parole? ☐ Yes ☐ No

If yes, explain: ______________________________

____

____

____

If on parole or probation, provide the name and contact information for your probation or parole officer.

____

____

Have you ever been incarcerated? ☐ Yes ☐ No

If yes, list the incident, the dates, the location, and any comments regarding the incarceration.

Incident	*Dates of Incarceration*	*Location*	*Comments*

VOCATIONAL HISTORY

Provide information on your vocational history, starting with your current or most recent employment.

Job Title/Employer	*Dates of Employment*	*Responsibilities*	*Reason for Leaving*

Have you ever been fired or let go from an employment position? ☐ Yes ☐ No

If yes, explain: ______________________________

ADDITIONAL INFORMATION

Provide information on your interests:

List any activities you dislike:

Write any additional comments that may assist in this evaluation:

Signature of Patient: ______________________ Date: ______________