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ADULT HISTORY FORM

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

INDIVIDUAL'S NAME:________________________________ Birthdate: _________________

Completed by:____________________________________ Date completed:_____________

Highest Grade Completed: ________ Major, if any: _________________ Degrees, if any: ____

Phone: ____________________________________

Primary Physician:_________________________ Phone: ______________________________

Please list any current therapies the individual is receiving with provider name and phone number:

Therapy	**Provider**	**Phone**	**Date Begun**

Birth and Developmental History:

Information requested pertains to the biological mother of the individual:

1. Did the mother receive prenatal care? Y N

2. Did the mother take any medications during pregnancy? Y N

Name of medication	Reason taken	Trimester

3. Did the mother smoke cigarettes, drink alcohol, or use drugs during pregnancy? Y N

Substance	Amount used per week	Trimester

____
____
____
____

4. Did the mother experience any medical problems during pregnancy? Y N If so, please describe:

____

____

____

5. Length of pregnancy: _____ weeks Age of mother:______

6. Were there any problems with the delivery? Y N If so, please describe:

____

____

____

Delivery was: Vaginal___ C-section___

7. Birth weight:_______
8. Duration of mother's hospital stay: ________ Baby's hospital stay:_________
9. Were there any problems noted by anyone while the baby was still in the hospital? (for example, prolonged jaundice, need for incubator/oxygen, feeding problems, colic) ____________________

____

10. Did the individual have any medical problems during infancy? _________________________

____

Feeding difficulties?____

"Colic"?____

Sleep difficulties?____

11. How would you describe the individual's temperament as an infant? (Was he/she an "easy" baby?

Was he/she cuddly?) ____

____

12. At what age did the individual complete the following developmental milestones?

Milestone	Age
Smile	______
Sit	______
Walk	______
First words (other then “mama” and “dada”)	______
2-3 word sentences	______
Toilet trained during day	______

Medical History

1. Does the individual have any chronic health issues (e.g. asthma, genetic syndromes, diabetes)?

____

____

2. Has the individual had any surgeries or hospitalizations? Y N

Year of surgery	Procedure/Reason for Hospitalization	Outcome

3. Has the individual ever had a seizure? Y N

If so, please describe dates of seizures, any diagnostic testing performed, and any medications given.

____

____

4. Has the individual ever had a head injury? Y N

If so, please describe dates and circumstances. Did the individual lose consciousness? Was a CT scan or MRI performed? ____
____

5. Is the individual taking any type of medication currently? Y N

Name of medication	Dosage	Reason	Date begun

6. Has the individual ever taken any psychiatric medications in the past? Y N

Name of medication	Dosage	Reason	Dates

7. Has the individual ever had a vision screen? Y N

Date of screen:______________________ Results:_____________________

8. Has the individual ever had a hearing screen? Y N

Date of screen:_____________________ Results:_____________________

9. Please list any evaluations for the individual (neurology, educational, developmental pediatrics, psychologist). **Please bring copies of these evaluations to your first appointment.**

Type	By whom	Year	Diagnoses

General Information

1. Please list information regarding the individual's legal parent(s):

Name	______________________________	________________________
Educational level	______________________________	________________________
Occupation	______________________________	________________________
Age	______________________________	________________________
Religion/Spirituality	______________________________	________________________

2. Is the individual living with his/her parents? Y N

If not, describe living arrangements:____
____

3. Please list sibling(s):

Name   Age   Full/half/adoptive/step?   Living in your home?
____

____

____

4. If the individual is on a special diet, please describe: _______________________________

____

5. If the individual has any sensitivities to light, noise, touch, etc. please describe: ___________

____

6. Does the individual currently have any problems with sleep? (e.g., falling asleep, frequent wakings) ____
_____

7. Please list the goals you have for our work together: _______________________________

____

____

Family History

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

	MOTHER	FATHER	MOTHER’S FAMILY	FATHER’S FAMILY	INDIVIDUAL’S SIBLINGS
Attention Problems					
Social Awkwardness					
Learning problems					
Language Delay					
Autism Spectrum					
Hyperactivity					
Problems w/ Anger					
Drug/Alcohol Abuse					
Depression					
Suicide Attempt(s)					
Problems w/ Anxiety					
Bipolar Disorder					
Schizophrenia					
Psychosis					
Criminal History					