Name: Date:

HISTORY QUESTIONNAIRE

Name _____ Today's date _____ Date of birth _____ Age _____

Marital status (circle one): single married divorced widowed live-in partner other _____
Please list all current medications and dosages (include non-prescription drugs & supplements):
_____
_____
Briefly describe the concerns or problems that bring you here:
_____
_____
When did these first occur? _____
Has there been any change over time (better? worse?) _____
How are these problems affecting you at home? _____
_____
At work or school? _____
_____
In relationships? _____
_____
In other areas? _____
_____

DEVELOPMENTAL, EDUCATIONAL, & OCCUPATIONAL HISTORY

Were there any medical complications when your mother was pregnant with you? Yes No Don't know
If yes, please describe? _____
Were you born prematurely? Yes No If yes, how many weeks? _____
Were there complications at birth? Yes No If yes, explain _____
Birth weight: _____ Age at which you began: to walk _____ to talk _____

What is your highest level of education? _____
Were you held back in school? Yes No If yes, what grade(s)? _____
Did you have tutoring in school? Yes No If yes, in what subject(s)? _____
Were you placed in special classes? Yes No If yes, when? _____
Did you have speech therapy? Yes No If yes, at what age? _____
Place a check by those subjects with which you had difficulties:

Reading _____	Math _____	History _____
Writing _____	Art _____	Foreign Lang. _____
Spelling _____	P.E. _____	Other: _____

What were your best or strongest subjects? _____

Were you ever told that you have a learning disability? Yes No If yes, what type? _____

Did you have motor coordination problems? Yes No Describe: _____

Were you considered to be a discipline problem in school? Yes No If yes, how so? _____

Elementary education (circle one): private public combination Grades/Marks: _____

High school education (circle one): private public combination Grades/Marks: _____

How old were you when you finished high school (or left school)? _____

Name: Date:

If you attended college or trade school, what school(s) did you attend? _____

Your major? _____ Your grade point average? _____ Did you graduate? _____

If you attended graduate, professional, or trade school, where did you go? _____

What was your field of study? _____

Did you complete your degree? Yes No What was your GPA? _____

Are you currently employed? Yes No Retired If yes, how long at this job? _____

If yes, please describe your work: _____

If no, what was the nature of the last job you had? _____

If retired, when? _____

What other kinds of work have you done? _____

Did you serve in the military? Yes No If Yes, dates & branch of service: _____

MEDICAL HISTORY

Please list any current/active medical problems: _____

_____

When was your last medical checkup? _____

Please indicate whether you currently use any of the following:

Alcohol? Yes No If yes, how much in an average week? _____
Caffeine? Yes No If yes, how much in an average day? _____
Tobacco? Yes No If yes, how much in an average day? _____
Marijuana? Yes No If yes, how much in an average week? _____
Other street drugs? Yes No If yes, which ones & how often? _____

Have you ever

Felt you ought to cut down on your drinking or drug use? _____
Had people annoy you by criticizing your drinking or drug use? _____
Felt bad or guilty about your drinking or drug use? _____
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a Hangover or to get the day started? _____

Please indicate whether you have a problem with any of the following:

Sleep? Yes No Describe: _____
Appetite? Yes No Describe: _____
Weight? Yes No Describe: _____
Sex drive? Yes No Describe: _____

Please list any past major illnesses, injuries, or surgeries:
Illness/Injury/Surgery Age at onset

_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had a head injury? Yes No If yes, describe _____

_____

Name: Date:

Did you lose consciousness? Yes No Were you treated medically? Yes No

Do you have headaches? Yes No If yes, describe: _____

Have you ever had a seizure? Yes No If yes, describe: _____

Have you been exposed to toxins? Yes No If yes, describe: _____

Have you been tested for AIDS/HIV? Yes No If yes, was it positive? _____

PLEASE INDICATE WHETHER YOU HAVE (OR HAD) A PROBLEM WITH ANY OF THE FOLLOWING:

Cognition:

____ Memory _____
____ Episodes of confusion _____
____ Speech _____
____ Reading _____
____ Writing _____
____ Spelling _____
____ Reading maps _____
____ Right/left confusion _____
____ Getting lost _____
____ Attention/Concentration _____
____ Daytime sleepiness _____

Sensorimotor:

____ Eyes/Vision _____
____ Ears/Hearing _____
____ Taste _____
____ Smell _____
____ Dizziness/Vertigo _____
____ Balance _____
____ Coordination _____
____ Walking _____
____ Numbness/Tingling _____
____ Tremors or Tics _____
____ Hyperactivity _____
____ Fatigue _____
____ Muscular symptoms _____
____ Uncontrolled movements _____
____ Swallowing _____
____ Pain _____

WOMEN ONLY:

Menstrual problems? Yes No Describe: _____
PMS? Yes No Describe: _____
Hysterectomy? Yes No Age? _____
Postmenopausal? Yes No Age? _____
Other gynecological problems? Yes No Describe: _____

MEN ONLY:

Prostate problems? Yes No Describe: _____
Genitourinary problems? Yes No Describe: _____

Name: Date:

General Health:

____ Allergies _____
____ Blood pressure _____
____ Heart problems _____
____ Chest pain _____
____ Anemia/blood problems _____
____ Diabetes _____
____ Vascular (blood vessels) problems _____
____ Stomach or bowel _____
____ Liver problems _____
____ Kidney problems _____
____ Urinary problems _____
____ Lung problems _____
____ Pancreas or gall bladder _____
____ Thyroid/Hormones _____
____ Joint pain/Arthritis _____
____ Cancer/tumors _____
____ Other _____

Have you ever had a brain scan? Yes No If yes, what type? (circle) MRI CT scan

When? _____ Where? _____ Why? _____

What were the results of the scan? _____

Have you ever had an EEG (brain wave)? Yes No

When? _____ Where? _____ Why? _____

What were the results of the EEG? _____

PSYCHIATRIC HISTORY

Have you ever participated in therapy before? Yes No With whom? _____

If yes, what was the experience like? _____

Have you ever taken any psychiatric medications (e.g., antidepressants)? Yes No

If yes, which ones? _____

Have you ever been hospitalized for psychiatric reasons? Yes No If yes, describe: _____

_____

Have you ever experienced any of the following (check all that apply)? If unsure, use a "?":

____ Racing or tangential thoughts
____ Intrusive or disturbing thoughts
____ Paranoia or the sense that others are watching you
____ Feelings of unreality or depersonalization (e.g., feeling outside your body)
____ Bullying _____
____ Episodes of intense anxiety or fear
____ Panic attacks
____ Uncontrolled anger or violent behavior
____ Mood swings
____ Depressed mood
____ Suicidal thoughts
____ Attempted suicide
____ Mania or hypomania (e.g., periods of very high energy with prolonged lack of sleep)
____ Hallucinations (e.g., hearing voices or seeing things that others do not perceive)
____ Physical or sexual abuse or assault _____
____ Compulsions (e.g., excessive hand washing; frequently checking locks)
____ Eating disorder _____
____ Self-harming behaviors without suicidal intent (e.g., cutting, burning)

Name: Date:

FAMILY MEDICAL & PSYCHIATRIC HISTORY (Please provide complete information)

	Current Age	Age at Death	Medical and Psychiatric History
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

SOCIAL HISTORY

Spouse/partner's name: _____ Age? _____ Length of relationship: _____

Previous marriages, if any: You _____ Partner _____

Names/ages of children (include step-children): _____

Were your parents divorced? ____ If yes, how old were you? _____ Which parent had custody? _____

How would you describe your relationship with your family-of-origin? _____

How would you describe your current significant relationships? _____

How would you describe your social life? _____

What kind of work did/do your parents do? Father: _____Mother: _____ Step-parent:_____

Do you attend religious services on a regular basis? Yes No Comments:_____

What is your religious background? _____ Current preferences? _____

Do you exercise regularly? Yes No If yes, what do you do?_____ _____

What are your interests or hobbies? _____

What are your strengths or talents? _____

Do you have any problems driving? Yes No If yes, describe: _____

Do you talk on a cell phone while driving? Yes No

Have you ever been arrested? Yes No If yes, describe: _____

Are you currently involved in a lawsuit? Yes No If yes, describe: _____

If there is any other information that you think is important for me to know, please write it below:

_____

_____

Name of person who completed this form if other than the patient/client: _____

Relationship to patient/client: _____

Name: Date:

SELF-DESCRIPTION CHECKLIST: Please check each item below that describes your *current* feelings.

___Abused
___Ambitious
___Angry
___Anxious
___Apathetic
___Ashamed
___Bereaved
___Cheerful
___Confused
___Dangerous
___Depressed
___Distrustful
___Energetic
___Fatigued
___Fearful
___Forgotten
___Fretful
___Guilty
___Happy
___Hopeful
___Hopeless
___Hurt
___Inadequate
___Indifferent
___Irritable
___Isolated
___Jealous
___Lonely
___Loss of control
___Loss of faith/God
___Loss of love
___Loss of meaning
___Loss of self-respect
___Marital/partner stress
___Neglected
___Numb
___Optimistic
___Outgoing
___Overeating
___Panicked
___Puzzling ideas
___Resentful
___Sad
___Spiritual worries
___Suicidal
___Unhappy
___Violent
___Work stress
___Worried

Other: _____