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ADULT HISTORY FORM Date_____

Completed this form Patient___ Spouse___ Parent___ Other_____

Patient's Name_____ Date of Birth_____
Age_____ Sex_____ Race_____ Marital Status_____
Phone: Home_____ Work_____ Cell_____

Briefly explain why you need this evaluation

_____
_____
_____
_____

Injured while working (Workers' Comp) No____ Yes____ Date_____
Injured in accident No___ Yes___ Cause_____ Date_____
Involved in a lawsuit No___ Yes___ Explain_____
Applying for Disability No___ Yes___ Granted____ Denied____ Date_____
Do you have an attorney No___ Yes___ Attorney's Name_____

Any thinking problems (attention or memory problems, etc.) No____ Yes____

_____
_____
_____

When problems started_____
Started Suddenly_____ Slowly_____; Got Better_____ Worse_____ Same_____

Any changes in your
Memory No___ Yes___ Explain_____
Speech No___ Yes___ Explain_____
Appearance No___ Yes___ Explain_____
Mood No___ Yes___ Explain_____
Movements No___ Yes___ Explain_____

Medical History
Did your mother have any problems during her pregnancy with you
No_____ Unknown_____ Yes_____ (explain)_____
Was your birth premature or were there complications
No_____ Unknown_____ Yes_____ (explain)_____
Problems with your childhood development
No_____ Unknown_____ Yes_____ (explain)_____

Please list current and past medical illnesses **Age**

_____
_____
_____
_____
_____
_____
_____

Please list surgeries/hospitalizations **Age**

_____
_____
_____
_____
_____
_____

Ever had

Loss of consciousness / coma Yes____ Age_____ Explain_____
Lead or other poisoning Yes____ Age_____ Explain_____
Fever of 104 or above Yes____ Age_____ Explain_____
Brain damage Yes____ Age_____ Explain_____
Brain surgery Yes____ Age_____ Type_____
Meningitis Yes____ Age_____ Explain_____
Multiple sclerosis Yes____ Age_____
Parkinson's disease Yes____ Age_____
Cancer Yes____ Age_____ Type_____
Diabetes Yes____ Age_____ Type_____
High blood pressure Yes____ Age_____
Low blood pressure Yes____ Age_____
Headaches Yes____ Age_____ Explain_____
Heart attack Yes____ Age_____
Sleeping problems Yes____ Age_____ Explain_____
Sleep apnea Yes____ Age_____
Arthritis Yes____ Age_____ Explain_____
Chronic pain Yes____ Age_____
Chronic fatigue Yes____ Age_____
Fibromyalgia Yes____ Age_____
Vision problems Yes____ Age_____
Cataract surgery Yes____ Age_____ Both___ Left___ Right___
Hearing problems Yes____ Age_____
Dizziness Yes____ Age_____
Tremors/shakiness Yes____ Age_____
Frequent falling Yes____ Age_____
Allergies Yes____ Age_____
Asthma Yes____ Age_____
Injured arms/hands/fingers Yes____ Age_____ Explain_____
Other_____

Head injury/concussion

Age_____ What happened_____
Black Out No___ Yes___ How Long_____ Remember the event No___ Yes____
Go to the hospital No_____ Yes_____ Treatment No_____ Yes_____
Explain_____

Last clear memory before injury_____
First clear memory after injury_____
Symptoms you had_____
How long to recover_____
Lasting problems_____

More than one head injury
Age_____ What happened_____
Black Out No___ Yes___ How Long_____ Remember the event No___ Yes____
Go to the hospital No_____ Yes_____ Treatment No_____ Yes_____
Explain_____

Last clear memory before injury_____
First clear memory after injury_____
Symptoms you had_____
How long to recover_____
Lasting problems_____

Seizure
Age first seizure_____ Last seizure_____ Describe_____
Pass out during seizure No____ Partially____ Completely____ How long_____
How long to recover after seizure_____
Number of seizures per day, week, or month_____
Mediations do you take for seizures_____

Neuroimaging / testing

EEG	Date or Age_____	Results_____
CT	Date or Age_____	Results_____
MRI	Date or Age_____	Results_____
PET/ SPECT	Date or Age_____	Results_____
Psychological Testing	Date or Age_____	Where_____
Neuropsychological Testing	Date or Age_____	Where_____

Current medications and reason for taking

_____
_____
_____
_____
_____
_____
_____
_____

Medications taken in the past for 2 months or more

_____
_____
_____
_____

Caffeine Use
Drink or use caffeine (cola, coffee, tea, energy drinks) No_____ Yes_____
What kind and how much a day_____

Tobacco Use
Use tobacco No_____ Yes_____ How much per day_____
How long have you used tobacco_____
Did you use tobacco in the past No_____ Yes_____ How much_____
When did you stop _____ Why did you stop _____

Alcohol Use
Do you drink alcohol No_____ Yes_____ How much per day_____
For how long (since what age) _____
Did you use alcohol in the past No_____ Yes_____ How much_____
When did you stop _____ Why did you stop _____

Street drugs or medications used without a prescription
Marijuana, Pot, Weed, Synthetic; LSD, Acid, PCP; Mushrooms, Ecstasy, MDMA
Cocaine, Crack; Methamphetamine, Speed; Ritalin, Adderall, Diet Pills
Lortab, OxyContin, Demerol, Vicodin, Codeine, Heroin, Morphine, Methadone
Valium, Xanax, Klonopin, Ativan, Barbiturates, Benzodiazepine, Halcion
Glue, Paint Thinner, Gasoline, Nitrous Oxide, Laughing Gas
Other_____

For each drug

Name	First time	How often	Last time

Problems because of alcohol or drugs
Relationship problems No___ Yes___ Explain_____
Job problems No___ Yes___ Explain_____
Legal problems No___ Yes___ Explain_____

Treatment to stop using drugs or alcohol No_____ Yes _____

Place / Facility	Date	How long

Mental Health
Ever have really bad anxiety or depression, suicidal thoughts or feelings, or ever attempt suicide or hurt yourself on purpose No_____ Yes_____

Past or current psychological or psychiatric evaluation or treatment

Type of Treatment	Age	Reason

Social and Family History
Served in the military No___ Yes___ Branch_____ How long_____
Highest Rank _____ Type of Discharge_____

Ever arrested No___ Yes___ Charges_____
_____
_____
_____

Driver's license No_____ Yes_____ Drive now No_____ Yes_____
Hobbies, interests, activities_____
_____
Hand you write with_____ Left-handed family members_____

Family receive mental health treatment or hospitalized No_____ Yes_____
Explain_____

Parental Information
Mother's education_____ Job_____
Medical/Psychiatric Problems_____

Father's education_____ Job_____
Medical/Psychiatric Problems_____

Educational History
Graduated high school No_____ Yes_____ Explain_____
Highest grade finished_____ Grades_____ GED No___ Yes___ When_____
Repeat any grades No_____ Yes_____ Explain_____
Special education No_____ Yes_____ Explain_____

Any College No_____ Yes_____ Degree_____ Major_____ Years_____
College Name_____ Location_____
Technical or Vocational Training No_____ Yes_____ Where_____
Explain_____

Employment History
Employed now
No____ How long unemployed_____ Reason_____
Yes___ How long at your job_____ Job title_____

Please describe your past jobs

Dates worked	Job title	Job duties	Reason for leaving

Who lives with you

Name	Age	Relationship

How you slept the night before this evaluation_____

Anything else you would like us to know?_____
_____
_____