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)? ____

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 ____________________________________

____

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: ___________________________________

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)
____ Frequent episodes of déjà vu
____ 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)
____ Victim of 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)

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: ____________________