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 ____

____

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)
____ 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: ____________________