



741 Sesame Street, Suite 1B  
Anchorage, AK 99503  
Phn: 907-334-1000 Fax: 907-334-8080  
Web: [www.akpsychservices.com](http://www.akpsychservices.com)

## Adult History Form

The Purpose of this questionnaire is to gather information about your history and present situation so that we may provide the most appropriate clinical services. Please answer each question as accurately as possible. No one will be allowed to see your records without your permission.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: Female Male

This form completed by: \_\_\_\_\_ Today's Date \_\_\_\_\_

With whom do you reside? \_\_\_\_\_

Home Address \_\_\_\_\_

STREET

CITY

STATE

ZIP

Email: \_\_\_\_\_ Best contact Phone number: \_\_\_\_\_

Are you?  Single  Married  Separated  Divorced  Widowed  Unmarried

Place of Birth: \_\_\_\_\_ Ethnicity \_\_\_\_\_

Are you adopted? Y N Age at Adoption: \_\_\_\_\_ Handedness:  Right  Left  Both

Do you have children?

Name	Age	Sex	Grade	How is school going?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other people in the household:

Name	Age	Sex	Relationship to Patient
_____	_____	_____	_____
_____	_____	_____	_____

### Area of Concern:

Who referred you for evaluation? \_\_\_\_\_

For what current problems or symptoms are you seeking help? \_\_\_\_\_

How long have you had these problems? \_\_\_\_\_

Have these problems become worse over time? Yes \_\_\_\_\_ No \_\_\_\_\_

What other types of treatment/evaluations have you had? \_\_\_\_\_  
\_\_\_\_\_

Have you had any of the following? (check all that apply)

- Neurological Exam \_\_\_ Spinal Tap \_\_\_ CT Scan \_\_\_ CT Scan \_\_\_ EEG \_\_\_ X-rays \_\_\_ MRI \_\_\_
- Evoked Potentials \_\_\_ Angiogram \_\_\_ Myelogram \_\_\_ EMG \_\_\_ CT \_\_\_ Other \_\_\_\_\_

If yes, what were the results? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Functional Changes (check all that apply)

Physical Functioning:

- Weakness/Hemiplegia \_\_\_ Coordination \_\_\_ Fatigue \_\_\_
- Headaches \_\_\_ Vision (R/L) \_\_\_ Hearing (R/L) \_\_\_
- Somatosensory/Pain \_\_\_ Appetite (Wt. Loss/Gain)\_\_\_ Sleep \_\_\_

Cognitive Functioning:

- Orientation \_\_\_ Memory \_\_\_ Speech \_\_\_
- Attention \_\_\_ Comprehension \_\_\_ Organization \_\_\_
- Planning \_\_\_

Personality/Interpersonal Relationship Changes:

- Personality Change \_\_\_ Sexual Functioning \_\_\_ Conduct/Behavior \_\_\_
- Insight/Awareness \_\_\_ Affect/Mood \_\_\_

Current Functional Status:

Please rate the following as: (D) Dependent (A) Needing Assistance or (I) Independent:

- |                            |                                  |  |
|----------------------------|----------------------------------|--|
| Bathing: ___               | Grooming (Hair/Teeth/Shave) ___  |  |
| Walking (Gait/Balance) ___ | Stairs (Number) ___              |  |
| Eating (Swallowing) ___    | Preparing Meals ___              |  |
| Toileting ___              | Incontinence (Bladder/Bowel) ___ |  |
| Dressing ___               | Other/Special Needs _____        |  |

Please specify any surgeries you have had performed: \_\_\_\_\_  
\_\_\_\_\_

**Medications:**

Who is your primary care physician? \_\_\_\_\_

Please list all allergies to medications and/or food: \_\_\_\_\_

Please list all current medications and dosages, and who prescribed them for you: \_\_\_\_\_

Please list current over-the-counter medications you are taking: \_\_\_\_\_

Please list any relevant previously prescribed medications: \_\_\_\_\_

**Neurological History:**

Have you ever had any of the following neurological problems:

- |  |     |     |    |     |                             |
|--|-----|-----|----|-----|-----------------------------|
| Head injury with loss of consciousness?    | Yes | ___ | No | ___ | If yes, how long? _____     |
| Head injury without loss of consciousness? | Yes | ___ | No | ___ |                             |
| Dazed, Confused, or Disoriented?           | Yes | ___ | No | ___ |                             |
| Heat Exhaustion/Sunstroke?                 | Yes | ___ | No | ___ |                             |
| Partial Drowning?                          | Yes | ___ | No | ___ |                             |
| Exposure to gases or fumes?                | Yes | ___ | No | ___ |                             |
| Electrical or chemical shock?              | Yes | ___ | No | ___ |                             |
| Fainting or dizzy spells?                  | Yes | ___ | No | ___ |                             |
| High fever over 103 degrees?               | Yes | ___ | No | ___ | If yes, for how long? _____ |
| Lead or other poisoning?                   | Yes | ___ | No | ___ |                             |
- Other: (specify) \_\_\_\_\_

**Social Functioning:**

Are you currently employed? Yes \_\_\_ No \_\_\_

If not, why? \_\_\_\_\_

How well do you form / maintain friendships /relationships with others? \_\_\_\_\_

Opposite Sex: \_\_\_\_\_

School/Work Colleagues: \_\_\_\_\_

Authority Figures: \_\_\_\_\_

Family: \_\_\_\_\_

Any anticipated changes in your support system? \_\_\_\_\_

**Family Medical History:**

Have you or any of your relatives had any of the following conditions? (Relatives include your biological parents, brothers and sisters, grandparents, aunts, uncles, and cousins.)

Condition	You	Mother	Father	Sibling	Grandparent	Cousin
Hyperactive						
Behavior Problems						
Reading Difficulty						
Writing Difficulty						
Math Difficulty						
Speech Problems						
Slow Development						
Deformities						
Depression						
Anxiety or Panic Attacks						
Bipolar Disorder						
Tic Disorder						
Alcohol Use						
Drug Abuse						
Overdose						
Intellectual Disabilities						
Cerebral Palsy						
Brain Hemorrhage						
Brain Tumor						
Encephalitis, Meningitis						
Convulsions, Seizures						
Severe Headaches						
Muscular Weakness						
Thyroid Disease						
Heart Disease						
Stroke						
Diabetes						
Anemia						
Rheumatic Fever						
Cancer						
Asthma						
Kidney/Bowel						
Early Deaths/Miscarriages						
Psychosis						
Dementia						

Please specify any other relevant family medical history/surgeries: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Hearing:**

Have you ever been diagnosed with a hearing impairment? Yes \_\_\_ No \_\_\_

If yes, please specify: \_\_\_\_\_

Have you been prescribed a hearing aid? Yes \_\_\_ No \_\_\_

If yes, do you wear it regularly? Yes \_\_\_ No \_\_\_

**Vision:**

When was your last eye exam? \_\_\_\_\_

What were the results of that exam? \_\_\_\_\_

Have you been diagnosed with any visual impairment? Yes \_\_\_ No \_\_\_

If yes, please specify: \_\_\_\_\_

**Sleep:**

Please specify your typical sleep pattern (time to fall asleep, time to rise, amount of sleep per night):

\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following difficulties? (Check all that apply)

- |                               |     |                |     |                    |     |
|-------------------------------|-----|----------------|-----|--------------------|-----|
| Falling asleep                | ___ | Staying asleep | ___ | Snoring/snorting   | ___ |
| Unpredictable length of sleep | ___ | Early riser    | ___ | Very heavy sleeper | ___ |
| Nightmares                    | ___ | Night terrors  | ___ | Sleep walking      | ___ |
| Other: (specify) _____        |     |                |     |                    |     |

**Eating:**

Do you eat a healthy diet from all four food groups? Yes \_\_\_ No \_\_\_

Do you have strange eating habits? Yes \_\_\_ No \_\_\_

Any recent change in your eating habits or appetite? Yes \_\_\_ No \_\_\_

If yes, please specify: \_\_\_\_\_

Any recent change in your weight? Yes \_\_\_ No \_\_\_

If yes, please specify gain or loss and how much over what period of time: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Substance Use:**

Do you smoke cigarettes? Yes \_\_\_ No \_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_

Do you use illicit substances? Yes \_\_\_ No \_\_\_

Do you abuse prescription medications? Yes \_\_\_ No \_\_\_

If yes, please specify: \_\_\_\_\_

**Developmental History:**

How many siblings do you have? \_\_\_\_\_

What is your birth order? \_\_\_\_\_

Do you know if your mother's pregnancy was: Uneventful \_\_\_ Complicated \_\_\_

Do you know if you were born: Full term \_\_\_ Premature at \_\_\_ weeks' gestation

Delivery: Vaginal \_\_\_ Cesarean \_\_\_

Birth Weight (pounds and ounces: \_\_\_\_\_ Breast Fed: Yes \_\_\_ No \_\_\_

Age of Mother at Delivery: \_\_\_\_\_ Age of Father at Delivery: \_\_\_\_\_



Are you under any particular stress at this time? Yes \_\_\_ No \_\_\_

If yes, please specify: \_\_\_\_\_

What are your particular strengths? \_\_\_\_\_

What are your hobbies, interests, recreational / leisure activities? \_\_\_\_\_

Any additional comments or concerns: \_\_\_\_\_

\_\_\_\_\_