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ADULT INITIAL HISTORY

Please fill this out as pertains to the person who will be undergoing the evaluation

Name: _____ Date of Birth: _____

Address: _____

Phone/email: _____ Emergency contact: _____

Who referred you to my office? _____

Presenting problem(s) and approximate date(s) of onset

Other issues/concerns

Goals of this consultation

What are your strengths?

26500 W. Agoura Rd., Suite 102-872
Calabasas, CA 91302
Neuropsychological Assessment
Consultation
tel 818 705-4305
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DEVELOPMENTAL HISTORY (as much as is known)

1. Pregnancy/delivery/infancy

Mother's age when you were born

Medications/alcohol/caffeine/health during pregnancy

Gestational age (# of weeks of pregnancy at which you were born)

Complications of labor/delivery Y/N If yes, please describe:_____

Your birth weight

Complications following birth? If so, what were they?: _____

Feeding problems Y/N Colic Y/N Health problems in infancy? Y/N

As a baby were you described as:

Easy/Average/Difficult? Social? Active?

Milestones – the age at which you:

Motor:	sat without support	crawled	walked
Language:	spoke first words	spoke phrases	spoke sentences

Handedness (left, right or ambidextrous)

You? R/L/A Siblings? R/L/A Father? R/L/A Mother? R/L/A

Maternal grandparents? R/L/A Paternal grandparents? R/L/A

2. Your Current Health

Overall: _____ Date of most recent physical:_____

Doctors you are currently seeing:

Name of doctor	Condition being treated
Name of doctor	Condition being treated
Name of doctor	Condition being treated
Name of doctor	Condition being treated

Medications you take:

Name of medication	Condition being treated
Name of medication	Condition being treated
Name of medication	Condition being treated
Name of medication	Condition being treated
Name of medication	Condition being treated

Do you wear glasses? Y/N Hearing aids? Y/N Are you colorblind? Y/N

How is your coordination? (walking/running/buttoning) Balance?

Are you hypersensitive to sensations (sticky things, clothing labels), light, sound?

Circle the following that you have experienced:

Traumatic Brain Injury (TBI)/Seizure/Loss of consciousness/Fainting)/Poisoning/Toxic exposure

Do you use and/or have you used:

Alcohol (frequency/amount):_____

Marijuana (frequency/amount):_____

Illegal drugs (type/frequency/amount):_____

Problems getting to sleep? Y/N Staying asleep? Y/N Nightmares? Y/N

Do you snore? Hours of sleep per night?

Do you have problems with food? Y/N If so, what are they:_____

Do you exercise? Y/N If so, what do you do and how often?_____

Height: Weight:

3. Psychiatric history
   a. Psychotherapy? Y/N If yes, when? For how long?_____
   b. Psychiatric hospitalizations? Y/N _____
   c. Traumas/Major events? Y/N _____

4. School and Employment History (academic, social, and behavioral performance)

Did you graduate high school? Y/N If not, highest grade you completed?_____

College/professional school? Where & what did you study?_____

Graduate school? Where & what did you study?_____

Did you receive special education? If so, for what?_____

Easiest subject(s)_____ Hardest subject(s)?_____

Employment history (feel free to attach resume/CV)

_____

_____

_____

Were you ever fired from a job? Y/N Do you work now? Y/N _____

What is/was hard for you at work? _____

What is/was easy?_____

5. Daily activities

How well do you manage money? _____

Do you pay your bills independently? Y/N If you get help, who helps?_____

Have you been a crime or scam victim? If so, what happened?_____

Do you drive? Y/N. Most recent driving ticket (when/for what)? _____

Do you get help with cooking, shopping, laundry, bathing, taking medications)? Y/N

If so, with what and from whom?_____

6. Psychosocial History

Parents together? How long? Stepparents?

Siblings? Ages? OK Please describe them and your relationship to them:

_____

_____

How was your childhood? Please describe:_____

_____

Are you in a committed relationship? Y/N How long?_____

Quality of the relationship:_____

What is your relationship history?_____

Do you have children? If yes, please describe them: _____

_____

What are you hobbies/interests?_____

_____

Do you have unrealized dreams? Regrets? If so, please describe: _____

_____

Do you worry? If so, about what: _____

_____

What do you do to cope with stress? _____

_____

7. Family History

Education: Mother?_____ Father?_____ Siblings?_____

Family medical problems: _____

_____

_____

Family Psychiatric History - close relatives who have:

Aggression problems?

Attention problems?

Learning disabilities?

Psychosis/schizophrenia?

Bipolar disorder/Manic depression?

Depression?

Anxiety?

Substance-abuse?

Physical/ sexual abuse?

Tics?

Intellectual Disability (previously “mental retardation”)?

Intellectual giftedness (“genius”)?

Autism Spectrum Disorder/Asperger’s?

8. Is there any additional information you would like me to know?