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PATIENT REGISTRATION AND HISTORY: *ADULT*

Date: _____ Referred by: _____

Name: _____ Other name(s) used: _____

DOB: _____ Gender: M or F Marital Status: _____

Address: _____
(Street) *(City)* *(Zip)*

Phone: Home: _____ Cell: _____ Other: _____

Email Address: _____

Ethnicity/Race: _____ Religion: _____

Primary Language: _____ Secondary Language: _____

Employment/School: _____ Title: _____

Hand used for writing: Left or Right Glasses or hearing aids: _____

Medical/psychological diagnosis, physician, and date (if any):

_____

Briefly describe the problems or symptoms and when they began: _____

_____

Are there specific questions you like answered?

_____

_____

Primary Health Insurance: _____ Subscriber Name: _____

Subscriber ID #:_____ Subscriber DOB: _____

SSN: _____

Secondary Health Insurance: _____ Subscriber Name: _____

Subscriber ID #:_____ Subscriber DOB: _____

This form was completed by: Patient: Y or N Other: _____
If not completed by the patient, please provide the following information: Name/Address/Phone/Relation

_____

Family History

The following questions deal with your BIOLOGICAL mother, father, brothers, and sister:

Mother

What is your mother's name (including maiden name): _____

Is she alive? Yes No If not, list cause of death: _____

Mother's occupation: _____

Mother's level of education obtained: _____

Mother's hobbies: _____

Does your mother have a known/suspected learning disability? Yes No

Briefly describe your mother's health history: _____

_____

Father

What is your father's name: _____

Is he alive? Yes No If not, list cause of death: _____

Father's occupation: _____

Father's level of education obtained: _____

Father's hobbies: _____

Does your father have a known/suspected learning disability? Yes No

Briefly describe your father's health history: _____

_____

When you were born, what was your mother's age? ___ Father's age? ___

How many brothers do you have? ___ How many sisters do you have? ___

Where are you in the birth order? _____

Are there unusual issues associated with any of your siblings? Yes No

If yes, please describe: _____

Family Life

Were you adopted? _____ No _____ Yes At what age? _____

Were you fostered? _____ No _____ Yes At what age? _____

Please list all household members currently living in your home and their relation to you:

Early History

Were you born: On time Late Prematurely (# of weeks ___)

Weight at birth: ___ lbs ___ ozs

Where were you born? _____

Were there any issues associated with your birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately following the birth (e.g. need for oxygen, special equipment used, convulsions, illness, etc.)? No Yes, describe:

_____

_____

Put a check next to all that applied to your mother while she was pregnant with you:

Accident	Alcohol use
Cigarette smoking	Drug use
Illness	Poor nutrition
Psychological issues	Other issues: _____

List all the medications (prescription or over the counter) your mother took while pregnant:

_____

During her pregnancy, did your mother live near a polluted area (toxic waste dump) or hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)? Yes No

If yes, describe: _____

Age of developmental milestones (indicate in months and or years):

Walking: _____

Language: _____

Toilet Training: _____

Overall development: _____

Medical History

Check all that currently apply:

□ AIDS, ARC or HIV	□ Brain disease or infection	□ Liver disease
□ Addiction to drugs	□ Cancer/chemotherapy	□ Lung disease
□ Alcohol problems	□ Heart disease	□ Stroke or CVA
□ Allergies	□ Hazardous substance exp	□ Psychiatric issues
□ Blood disorder	□ Kidney disease	
□ Diabetes	□ Hypertension	

Other: _____

Do you have epilepsy or a seizure disorder? Yes No

If yes, check the one you have been diagnosed with:

Partial:

- □ Simple partial (Jacksonian)
- □ Complex partial (Psychomotor)
- □ Partial evolving into generalized
- □ Unclassified type
- □ Don't know which type

Generalized:

- □ Absence (petit mal)
- □ Myoclonic
- □ Clonic
- □ Tonic
- □ Tonic-clonic (Grand mal)
- □ Atonic

Please describe: _____

Describe all hospitalizations (include purpose, length of stay, and location): _____

_____

_____

As a child, did you have any of the following conditions? (*Check all that apply*)

_____ Attention problems _____ Head injury _____ Speech delay
_____ Hearing problems _____ Hyperactivity _____ Clumsiness
_____ Frequent ear infections _____ Vision problems _____ Learning delay
_____ Development delay _____ Muscle tightness or weakness
_____ Other problems: _____

List any medications you currently take (prescription or over the counter):

Medication	Dosage	Frequency Taken	Date began Taking	Prescribed by	Prescribed for

Medical Informaiton

Who is your primary care physician:

Name: _____ Clinic: _____

Address: _____ Phone: _____

Updated immunizations and examinations: Yes No

Do you have a treating psychologist/psychiatrist?

Name: _____ Clinic: _____

Address: _____ Phone: _____

Start date of therapy: _____ Frequency of therapy: _____

Reason for therapy: _____

Have you had a previous psychological/neuropsychological evaluation? Yes No

If yes, please list the name and address of the psychologist and date administered:

_____

* Please provide a copy of the report at your intake appointment

Medical Testing

Circle all the medical tests completed recently (within the past year) and report any abnormal findings:

Angiography Blood work CT scan EEG MRI/FMRI PET/SPECT

Other test(s) _____

Please indicate all that existed in close biological family members (parents, siblings, grandparents, aunts, uncles, etc.). Note who it was and describe the issue where indicated:

Epilepsy or seizures _____

Learning disabilities _____

Left-handedness _____

Mental retardation _____

Speech or language disorder(s) _____

Neurological or Psychiatric Disorders

Alzheimer's disease _____

Bipolar disorder _____

Depression _____

Personality disorder _____

Schizophrenia _____

Other psychiatric disorders _____

Other major disease or disorder _____

Substance Use History

Alcohol

I drink alcohol: Rarely or never 3-5 days per week

1-2 days per week Daily

I use drink but stopped (date stopped): _____

I started drinking regularly at age: ___ Preferred type of drinks: _____

My last drink was: less than 24 hours ago 24-48 hours ago over 48 hours ago

Check all that apply:

□ I can drink more than most people my age and size before I feel drunk

□ I sometimes get into trouble after drinking

□ I sometimes blackout during or after drinking

Drugs

Please check all drugs you are currently using or have used in the past:

	Presently using	*Used in the past*
□ Amphetamines		
□ Barbiturates		
□ Cocaine or crack		
□ Hallucinogens		
□ Marijuana		
□ Opiates/Narcotics (Heroin)		
□ PCP		

List any other drugs, including designer and "non-harmful" of "non-addictive" drugs: _____

_____

Do you consider yourself dependent on any of the above drug(s)? Yes No

Do you think you are dependent on any prescription drug(s)? Yes No

Check all that apply:

□ I have gone through drug withdrawal

□ I have used IV drugs

□ I have been in drug treatment

Personal History

Education

Highest grade or degree earned: _____

Schools attended: _____

Describe academic performance? A & B's B & C's C & D's D & F's

Please provide any additional/helpful comments about your academic performance:

_____

What was your best subject? _____ Weakest? _____

Were you ever held back a grade? Yes No If yes, which grade? _____

Were you in special classes/received special education services? Yes No

Recreation

Briefly list the types of recreation you enjoy: _____

Military

Branch: _____ Discharge rank: _____ Type of discharge: _____

Major duties: _____

List any injuries sustained: _____

Were you exposed to any dangerous or unusual substances during your services (Agent Orange, radiation, etc.)? If yes, list: _____

Occupational History

Current job title: _____How long at job? _____

Current job responsibilities: _____

Prior jobs and time spent at them: _____

_____

At any time on a job, were you exposed to toxic, hazardous, noxious or other dangerous or unusual substances? (ex. Lead, mercury, radiation, solvents, pesticides, chemicals, etc.)?

Yes No If yes, list: _____

SYMPTOM SURVEY

Please place a check next to the applicable symptom.

Problem Solving

Difficulty figuring out how to do new things
Difficulty figuring out how to do things
Difficulty planning ahead
Difficulty thinking as quickly as needed
Difficulty doing things in the right order
Changing a plan or activity
Figuring out problems most other people can do
Difficulty doing more than one thing
Difficulty verbally describing the steps involved in doing something
Difficulty completing an activity in a reasonable amount of time
Difficulty switching from one activity to another activity
Easily frustrated

Other problem solving difficulties:

_____

Speech, Language and Math Skills

Difficulty finding the right words to say
Odd or unusual speech sound
Difficulty understanding what others are saying
Difficulty with math
Unable to speak
Difficulty staying with one idea
Slurred speech
Difficulty spelling
Difficulty understanding what was read
Difficulty writing letters or words (not due to motor problems)

Other speech, language, or math problems:

_____

Nonverbal Skills

Difficulty telling right from left
Problems drawing or copying
Difficulty recognizing objects or people
Decline in musical abilities
Slow reaction time
Difficulty dressing
Difficulty doing things the child should automatically be able to do (e.g. brushing teeth, etc.)
Problems finding way around places the child has been to before
Unaware of things on one side of the body (right left)

Other nonverbal issues:

_____

Concentration and Awareness

Highly distractible
Loses train of thought easily
Problems concentrating
Becoming easily confused or disoriented
Blackout spells (fainting)
Mind goes blank
Doesn't feel very alert or aware of things

Other concentration or awareness issues:

_____

Memory

Forgetting where things are left (books, etc.)
Forgetting names
Forgetting what they should be doing
Forgetting where they are
Forgetting recent events (such as the last meal)
Forgetting past events (months/years)
Need hints to remember things
Forgetting the order of things
Forgetting facts
Forgetting how to do things

Other memory issues:

_____

Motor Coordination

Fine motor control problems
Weakness on one side of body
Difficulty walking or bumping into things
Tremor or weakness
Muscle tics or strange movements
Writing is very small
Writing is very large
Walking more slowly than other people
Feeling stiff
Balance problems

Difficulty starting to move
Muscles tire quickly

Other motor or coordination issues:

_____

Sensory

Loss of feeling or numbness
Tingling or strange skin sensations
Difficulty telling hot from cold
Problems seeing on one side
Blurred vision
Blank spots in vision
Need to squint or move closer to see clearly
Difficulty looking quickly from one objects to another object
Ringing in my ears or hearing strange sounds
Double vision
See "stars" or flashes of light
Losing hearing
Difficulty tasting food
Difficulty smelling
Smelling strange odors
Brief periods of blindness

Other sensory issues:

_____

Physical

Headaches
Dizziness
Nausea or vomiting
Loss of bowel control
Excessive tiredness

Other physical issues:

_____

Behavior

Indicate next to item all that apply:

Sadness or depression
Anxiety or nervousness
Sleeping problem
Become angry more easily
Euphoria (feeling on top of the world)
Much more emotional (cry more easily)
Feel as if I just don't care anymore
Doing things automatically (without awareness)
Less inhibited (do things I would not do before)
Difficulty being spontaneous
Change in eating habits

Other recent changes in behavior/personality:

_____

Circle the answer that best fits:

Overall, symptoms have developed:	Slowly	Quickly
Symptoms occur:	Occasionally	Often
Over the past 6 months symptoms have:	Stayed the same	Worsened