Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

Adult History Form

Please provide information to the best of your knowledge. If some questions are not applicable to you, write N/A. You may need to ask your parent about some information, or leave the space blank if you are unsure. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet. All information is confidential. Although lengthy, the information that you provide on this form will help me best assist you. Thank you for taking the time to complete it.

GENERAL INFORMATION:

Your name: _____ Today's Date: _____
First Middle Last

Gender: ☐ Male ☐ Female Birth date: _____ Age: _____

Address: _____
Number and Street City, State, Zip

Home Phone: _____ Alternate Phone: _____

Email Address:_____

Form completed by: _____ Relationship to Client: _____

REFERRAL INFORMATION:

Current Doctor:

Name: _____

Telephone: _____ Fax: _____

☐ **If you **DO NOT** want me to send a copy of the report to this physician, please mark here.

Who referred you to (how did you hear about) Main Line Neuropsychology, PLLC? _____

CURRENT CONCERNS:

What are your current concerns and how long have they been a concern?

_____

_____

_____

What type of services are you seeking?

_____

_____

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PRENATAL AND POSTNATAL HISTORY:

PRE-NATAL HISTORY:

Please answer which of the following conditions may have occurred during your mother's pregnancy with you and explain (month, amount, treatment, etc.) in the space below:

Yes	No		Yes	No	
☐	☐	Edema (swelling of the hands and feet)	☐	☐	Epilepsy (Seizure)
☐	☐	Vaginal bleeding (when? _____)	☐	☐	Infections (colds, flu, urinary tract)
☐	☐	Toxemia	☐	☐	Other illnesses
☐	☐	Emotional stress	☐	☐	Cigarettes used (average #/Day)
☐	☐	High blood pressure	☐	☐	Alcohol used
☐	☐	X-ray studies	☐	☐	Marijuana used
☐	☐	Hospitalization	☐	☐	Cocaine used
☐	☐	Fever	☐	☐	Other drugs used
☐	☐	Operations (specify below)	☐	☐	Injuries
☐	☐	Medications used (specify below)	☐	☐	Diabetes
☐	☐	Preterm labor			

Please explain all "Yes" answers

_____

_____

_____

BIRTH HISTORY:

Were you born on time? ☐ Yes ☐ No

If No, were you ☐ Early or ☐ Late Length of pregnancy (weeks)? _____

Age of your mother at your birth: _____ Age of your father at your birth: _____

Weight at birth: _____ Type of delivery (Please circle): C-Section or Vaginal

Please check the following conditions that may have occurred during delivery:

Type of Labor Onset: ☐ Induced ☐ Spontaneous

Type of Anesthesia: ☐ Gas ☐ Spinal ☐ Local

Presentation: ☐ Breech ☐ Head ☐ Transverse (sideways)

Please check the following problems that may have occurred during labor:

Yes	No		Yes	No	
☐	☐	Toxemia/eclampsia	☐	☐	Fetal distress
☐	☐	Maternal fever	☐	☐	Medications used (please specify: _____)

POST DELIVERY PERIOD:

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Check which of the following problems may have occurred after your birth and explain the amount and treatment in the space below.

Yes	No		Yes	No	
☐	☐	Trouble breathing	☐	☐	Jaundice
☐	☐	Cord around the neck	☐	☐	Poor feeding
☐	☐	Knot in cord	☐	☐	Required a blood transfusion
☐	☐	Prolapsed cord	☐	☐	Vomiting / reflux
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Floppy muscle tone
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Incubator care
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for ventilation	☐	☐	Fever

Please explain all "Yes" answers:

_____

_____

Number of days you stayed in the hospital after delivery:_____

Apgar Scores (if known): 1 minute _____ 5 minutes _____ 10 minutes _____

INFANCY:

Were any of the following present in you to a significant degree during your infancy? If so, please describe:

Yes	No		Yes	No	
☐	☐	Difficulty feeding	☐	☐	Extremely passive
☐	☐	Excessive irritability	☐	☐	Frequent head banging
☐	☐	Difficulty comforting	☐	☐	Excessive restlessness
☐	☐	Difficulty sleeping	☐	☐	Always had to be held
☐	☐	Did not like to cuddle	☐	☐	Significant separation anxiety

Please explain all Yes answers:

_____

HEALTH HISTORY:

MEDICATION HISTORY:

Do you take medication? ☐ Yes ☐ No

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

Please provide the name and phone number of the prescribing physician for each medication listed:_____

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_____

_____

MEDICAL HISTORY:

Please check which of the following you have had and note the age, any complications, and frequency below:

Yes	No		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems
☐	☐	Surgery	☐	☐	Hearing problems
☐	☐	Trauma (stitches / broken bones)	☐	☐	Asthma
☐	☐	Head trauma	☐	☐	Allergies
☐	☐	Loss of consciousness	☐	☐	Stomach aches
☐	☐	Coma	☐	☐	Excessive vomiting
☐	☐	Seizures	☐	☐	Pica (eating nonfood items)
☐	☐	Tics	☐	☐	Frequent ear infections
☐	☐	Staring spells	☐	☐	Epilepsy
☐	☐	Tremor	☐	☐	Diabetes
☐	☐	Poor muscle tone	☐	☐	Stroke
☐	☐	Falls frequently	☐	☐	High blood pressure
☐	☐	Anemia	☐	☐	Rheumatoid arthritis
☐	☐	Persistent high fever	☐	☐	Cancer
☐	☐	Headaches	☐	☐	Other:_____

Please explain all Yes answers:

_____

_____

Please check Yes/No for the following tests/labs you may have had:

Yes	No	
☐	☐	Brain Scan (CT/MRI): Date: _____ Results: _____
☐	☐	Lab Test (EEG): Date: _____ Results: _____
☐	☐	Genetic/Chromosome Test: Date: _____ Results: _____
☐	☐	Other:_____ Date: _____ Results: _____

SERVICES / INTERVENTION:

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Have you previously or do you currently participate in any of the following?:

	Frequency: (e.g.,times/week)	Duration:	Beginning/Ending Dates:	Where:
Speech & Language Therapy				
Occupational Therapy				
Physical Therapy				
Psychotherapy				
Psychiatric Care				
Neurologic Exam				
Other:				

DEVELOPMENTAL MILESTONES:

Please list the age at which you accomplished the following developmental milestones.

Milestone:	**Age Milestone Accomplished**	**Do you feel it was met On-Time, Early, or Late?**
Smiled in response (social smile)	_____	☐ On-Time ☐ Early ☐ Late
Sat independently	_____	☐ On-Time ☐ Early ☐ Late
Crawled independently	_____	☐ On-Time ☐ Early ☐ Late
Walked independently	_____	☐ On-Time ☐ Early ☐ Late
Said “mama” or “dada” specifically	_____	☐ On-Time ☐ Early ☐ Late
Said 1st word other than “mama” or “dada”	_____	☐ On-Time ☐ Early ☐ Late
Put two words together	_____	☐ On-Time ☐ Early ☐ Late
Put 4 to 5 sentences together to relate an experience	_____	☐ On-Time ☐ Early ☐ Late
You understood 100% of what your child said	_____	☐ On-Time ☐ Early ☐ Late
Knew primary colors	_____	☐ On-Time ☐ Early ☐ Late
Said the letters of the alphabet	_____	☐ On-Time ☐ Early ☐ Late
Printed first and last name	_____	☐ On-Time ☐ Early ☐ Late
Tied shoes	_____	☐ On-Time ☐ Early ☐ Late
Snapped, zipped, buttoned clothing	_____	☐ On-Time ☐ Early ☐ Late
Began to read	_____	☐ On-Time ☐ Early ☐ Late
Toilet trained (urine)	_____	☐ On-Time ☐ Early ☐ Late
Toilet trained (bowel)	_____	☐ On-Time ☐ Early ☐ Late

What language(s) is most often spoken in the home?: _____

Do you speak and/or understand any language other than English?: _____

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FAMILY HISTORY:

Age of your mother: _____

Age of your father: _____

Age of your siblings: _____

Your Marital Status:

☐ Married for _____ years ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Significant Other's Name: _____

Do you have children?: ☐ Yes ☐ No

If Yes, how many? _____

What are the ages of your children? _____

Names of Current Household Members	Age	Gender M / F	Relationship to You
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any immediate or extended family members with the following?

☐ Depression ☐ Learning Difficulties ☐ Mental Retardation

☐ Anxiety ☐ Attention-Deficit/Hyperactivity Disorder ☐ Obsessive-Compulsive Disorder

☐ Autism/Asperger's Disorder ☐ Eating Disorder ☐ Other:_____

☐ Schizophrenia ☐ Bipolar Disorder

Please explain relation to you (e.g., mother, father, sibling):_____

Have any of the following events occurred within the past 12 months?

☐ You were divorced or separated ☐ Changed job ☐ New baby at home

☐ Family accident or illness ☐ Death in family ☐ Conflict in family

☐ Family financial problems ☐ Family moved ☐ Other stressor: _____

Please explain:_____

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CURRENT EATING AND SLEEP HABITS:

EATING HABITS:

Are you overly concerned with your weight? ☐ Yes ☐ No
Do you restrict the amount of food that you eat? ☐ Yes ☐ No
Do you binge eat? ☐ Yes ☐ No
Do you purposefully vomit after eating to restrict weight gain? ☐ Yes ☐ No

SLEEP HABITS:

Do you have problems falling asleep? ☐ Yes ☐ No

If Yes, how long does it take for you to fall asleep? _____

Do you wake up in the middle of the night? ☐ Yes ☐ No

If Yes, how many times per night typically? _____

How long does it take for you to go back to sleep? _____

Do you snore? ☐ Yes ☐ No Are you restless during sleep? ☐ Yes ☐ No

Do you experience:
Nightmares ☐ Yes ☐ No
Night Terrors ☐ Yes ☐ No
Sleep Walking/Talking ☐ Yes ☐ No

How many hours total sleep do you currently sleep at night?_____

EMOTIONAL/BEHAVIORAL:

Describe your typical mood (e.g., happy, sad): _____

_____

_____

Have you currently (within the past 6 months) displayed any of the following frequently or intensively? (please check)

☐ Fainting, falling	☐ Anxiety	☐ Low frustration tolerance	☐ Physical aggression
☐ Social Isolation	☐ Unusual fears	☐ Impulsivity	☐ Cigarette use
☐ Lack of confidence	☐ Avoidance	☐ Hyperactivity	☐ Alcohol / Substance use
☐ Low self-esteem	☐ Poor concentration	☐ Irritability	☐ Obsessive-compulsive behaviors
☐ Crying episodes	☐ Short attention span	☐ Laziness	☐ Memory loss
☐ Unhappiness	☐ Distractibility	☐ Insomnia	☐ Mania
☐ Hearing voices	☐ Seeing things others do not see	☐ Eating/weight concerns	☐ Weight loss/weight gain
☐ Other:			

Please provide additional information about any of the above you feel would be helpful: _____

_____

_____

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Number of alcoholic beverages per week: _____
Do you have a history of cigarette use? ☐ Yes ☐ No
Do you have a history of illicit drug use? ☐ Yes ☐ No If Yes, what type:_____

PERSONAL/SOCIAL:

What are your main hobbies and interests? _____

_____

What are you most proud of about yourself? _____

_____

What do you enjoy doing most? _____

_____

What do you dislike doing most? _____

_____

How many close friends do you have? ☐ None ☐ A couple/few ☐ Several

How well do you get along with others? ☐ Worse than average ☐ Average ☐ Better than average

If worse than average, please explain:_____

EDUCATIONAL HISTORY:

Did you graduate from high school? ☐ Yes ☐ No If No, what is the highest grade completed? _____ GED? _____

Name of high school: _____

Location of high school (City, State): _____

Grades:_____

Did you receive Early Intervention Services? ☐ Yes ☐ No
Did you have an Individual Education Program (IEP)? ☐ Yes ☐ No
Did you receive 504 Accommodations? ☐ Yes ☐ No

If you attend or attended college or vocational school, please provide name: _____

Major(s):_____

Location of college (City, State): _____

Grades:_____

If you attend or attended graduate school, please provide name: _____

Major(s):_____

Location of college (City, State): _____

Grades:_____

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Has previous cognitive or academic/achievement testing been completed by school or by a private provider (e.g., neuropsychologist, psychologist)? ☐ Yes ☐ No Date:_____

*****If yes, please attach a copy of the evaluation.***

Briefly describe your current academic difficulties (if any):_____

_____

When was the problem first noticed? _____

Have you ever been retained? ☐ Yes ☐ No What grade? _____ Why? _____

Were you ever in any of the following educational programs in elementary, middle, or high school, and if yes, how long?

	Age(s) or Dates of Placement	Frequency of Intervention
☐ Gifted and Talented	_____	
☐ Resource Room Services	_____	_____
☐ Self-Contained Class	_____	
☐ Life Skills Class	_____	
☐ Behavioral/Emotional Disorders Class	_____	
☐ Counseling	_____	_____

Did you/do you use any instructional modifications in school/college?

☐ Preferential seating
☐ FM system
☐ Increased positive feedback
☐ Manipulatives in math
☐ Extended time to complete assignments
☐ Shortened or modified assignments
☐ Study Sheets
☐ Control of distractions
☐ Behavior modification program
☐ Additional instructions
☐ Peer teaching
☐ Reduced paper and pencil work
☐ Repeated review
☐ Outlines
☐ Positive reinforcers
☐ Behavior check cards / charts
☐ Predictable routines and classroom rules
☐ Other _____
☐ Technologic assistance (word processor, calculator, augmentative communication device, etc.)

EMPLOYMENT HISTORY:

Have you worked? ☐ Yes ☐ No

Name of company: _____

Position title: _____

Responsibilities: _____

Difficulties: _____

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Name of company: _____

Position title: _____

Responsibilities: _____

Difficulties: _____

Name of company: _____

Position title: _____

Responsibilities: _____

Difficulties: _____

Name of company: _____

Position title: _____

Responsibilities: _____

Difficulties: _____

ADDITIONAL COMMENTS:

Have any blood relatives of yours experienced problems similar to those you are currently experiencing?

☐ Yes ☐ No If Yes, please describe

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Please write any additional remarks you may have, or address any area of concern that I may have missed, in the space provided:

Printed Name: _____

Signature: _____Date: _____