

## 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?

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What type of services are you seeking?

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**Main Line Neuropsychology, PLLC**  
**Jennifer Badgley, PhD**  
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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                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Edema (swelling of the hands and feet) | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (Seizure)                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal bleeding (when? _____)         | <input type="checkbox"/> | <input type="checkbox"/> | Infections (colds, flu, urinary tract) |
| <input type="checkbox"/> | <input type="checkbox"/> | Toxemia                                | <input type="checkbox"/> | <input type="checkbox"/> | Other illnesses                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional stress                       | <input type="checkbox"/> | <input type="checkbox"/> | Cigarettes used (average #/Day)        |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                    | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol used                           |
| <input type="checkbox"/> | <input type="checkbox"/> | X-ray studies                          | <input type="checkbox"/> | <input type="checkbox"/> | Marijuana used                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalization                        | <input type="checkbox"/> | <input type="checkbox"/> | Cocaine used                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever                                  | <input type="checkbox"/> | <input type="checkbox"/> | Other drugs used                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Operations (specify below)             | <input type="checkbox"/> | <input type="checkbox"/> | Injuries                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications used (specify below)       | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Preterm labor                          |                          |                          |  |

Please explain all "Yes" answers

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**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                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Toxemia/eclampsia | <input type="checkbox"/> | <input type="checkbox"/> | Fetal distress                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Maternal fever    | <input type="checkbox"/> | <input type="checkbox"/> | Medications used (please specify: _____) |

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***POST DELIVERY PERIOD:***

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                       |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble breathing                  | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Cord around the neck               | <input type="checkbox"/> | <input type="checkbox"/> | Poor feeding                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Knot in cord                       | <input type="checkbox"/> | <input type="checkbox"/> | Required a blood transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolapsed cord                     | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting / reflux            |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhage (bleeding) in head      | <input type="checkbox"/> | <input type="checkbox"/> | Floppy muscle tone           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hydrocephalus (water on the brain) | <input type="checkbox"/> | <input type="checkbox"/> | Incubator care               |
| <input type="checkbox"/> | <input type="checkbox"/> | Cyanosis (turned blue)             | <input type="checkbox"/> | <input type="checkbox"/> | Infection                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Need for ventilation               | <input type="checkbox"/> | <input type="checkbox"/> | Fever                        |

Please explain all "Yes" answers:

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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                       |                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty feeding     | <input type="checkbox"/> | <input type="checkbox"/> | Extremely passive              |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive irritability | <input type="checkbox"/> | <input type="checkbox"/> | Frequent head banging          |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty comforting  | <input type="checkbox"/> | <input type="checkbox"/> | Excessive restlessness         |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty sleeping    | <input type="checkbox"/> | <input type="checkbox"/> | Always had to be held          |
| <input type="checkbox"/> | <input type="checkbox"/> | Did not like to cuddle | <input type="checkbox"/> | <input type="checkbox"/> | Significant separation anxiety |

Please explain all Yes answers:

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***HEALTH HISTORY:***

***MEDICATION HISTORY:***

Do you take medication?  Yes  No

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

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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                       |                             |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations                 | <input type="checkbox"/> | <input type="checkbox"/> | Vision problems             |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery                          | <input type="checkbox"/> | <input type="checkbox"/> | Hearing problems            |
| <input type="checkbox"/> | <input type="checkbox"/> | Trauma (stitches / broken bones) | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Head trauma                      | <input type="checkbox"/> | <input type="checkbox"/> | Allergies                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of consciousness            | <input type="checkbox"/> | <input type="checkbox"/> | Stomach aches               |
| <input type="checkbox"/> | <input type="checkbox"/> | Coma                             | <input type="checkbox"/> | <input type="checkbox"/> | Excessive vomiting          |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures                         | <input type="checkbox"/> | <input type="checkbox"/> | Pica (eating nonfood items) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tics                             | <input type="checkbox"/> | <input type="checkbox"/> | Frequent ear infections     |
| <input type="checkbox"/> | <input type="checkbox"/> | Staring spells                   | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremor                           | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor muscle tone                 | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Falls frequently                 | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure         |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                           | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis        |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent high fever            | <input type="checkbox"/> | <input type="checkbox"/> | Cancer                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches                        | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                |

Please explain all Yes answers:

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

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Scan (CT/MRI): Date: _____ Results: _____     |
| <input type="checkbox"/> | <input type="checkbox"/> | Lab Test (EEG): Date: _____ Results: _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Genetic/Chromosome Test: Date: _____ Results: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ Date: _____ Results: _____             |

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**SERVICES / INTERVENTION:**

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.

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

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

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

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What are you most proud of about yourself? \_\_\_\_\_

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What do you enjoy doing most? \_\_\_\_\_

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What do you dislike doing most? \_\_\_\_\_

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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): \_\_\_\_\_

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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
<input type="checkbox"/> Gifted and Talented	_____	
<input type="checkbox"/> Resource Room Services	_____	_____
<input type="checkbox"/> Self-Contained Class	_____	
<input type="checkbox"/> Life Skills Class	_____	
<input type="checkbox"/> Behavioral/Emotional Disorders Class	_____	
<input type="checkbox"/> Counseling	_____	_____

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

- |   |   |
|---|---|
| <input type="checkbox"/> Preferential seating   | <input type="checkbox"/> Additional instructions                  |
| <input type="checkbox"/> FM system  | <input type="checkbox"/> Peer teaching                            |
| <input type="checkbox"/> Increased positive feedback  | <input type="checkbox"/> Reduced paper and pencil work            |
| <input type="checkbox"/> Manipulatives in math  | <input type="checkbox"/> Repeated review                          |
| <input type="checkbox"/> Extended time to complete assignments  | <input type="checkbox"/> Outlines                                 |
| <input type="checkbox"/> Shortened or modified assignments  | <input type="checkbox"/> Positive reinforcers                     |
| <input type="checkbox"/> Study Sheets   | <input type="checkbox"/> Behavior check cards / charts            |
| <input type="checkbox"/> Control of distractions  | <input type="checkbox"/> Predictable routines and classroom rules |
| <input type="checkbox"/> Behavior modification program  | <input type="checkbox"/> Other _____                              |
| <input type="checkbox"/> 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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