HUFFMAN PSYCHOLOGY, PLLC
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ADULT HISTORY FORM

For Office Use Only: Interview held on	from	to	with

Instructions: Please answer all of the following questions to the best of your ability. Notes

Name: _____ Date: _____
Address: _____ Date of birth: _____ Age: _____
_____ Sex: ☐ Male ☐ Female
Home phone: _____ Work phone: _____
Cell phone/other phone: _____ Email: _____
Handedness: ☐ right handed ☐ left handed ☐ both (explain): _____
Highest grade completed: _____ Area of study: _____
Primary care physician, address, and phone: _____
_____
Name of person completing form: _____ Relationship to patient: _____

REFERRAL INFORMATION:
Who referred you for an evaluation/psychological services? _____
What are you hoping to learn from this evaluation/psychological services? _____
_____
_____
Current Symptoms: _____
_____
Lab Findings: _____
_____
Overall, my symptoms have developed: ☐ Slowly ☐ Quickly

EARLY HISTORY:
1) Were you born: ☐ On time ☐ Prematurely ☐ Late
2) Birth weight: _____
3) Were there any problems associated with:
your mother's pregnancy (describe) _____
your birth (e.g., oxygen deprivation, unusual birth position, etc.) _____
the period immediately after birth (e.g., need for oxygen, special equipment used, convulsions, illness, etc.) _____
4) Rate your developmental progress to the best of your knowledge:

	Early	Average	Late
Walking	_____	_____ (10-16 mos.)	_____
Language	_____	_____ (12-24 mos.)	_____
Toilet training	_____	_____ (18-36 mos.)	_____

5) As a child, did you have any of these conditions? (Check all that apply):

☐ Frequent ear infections	☐ Head injury	☐ Behavioral problems
☐ Clumsiness	☐ Hearing problems	☐ Speech problems
☐ Developmental delay	☐ Hyperactivity	☐ Vision problems
☐ Attention problems	☐ Learning disability	☐ Psychological problems

Other problems: _____

MEDICAL HISTORY:

Medical illnesses as a child: _____

_____

_____

Medical illnesses as an adult: _____

_____

_____

_____

[LOC FEB SZ TOX SENS BAL/GT]

Do you have hearing problems? ☐ Yes ☐ No Vision Problems? ☐ Yes ☐ No

Have you ever suffered an injury to your head? ☐ Yes ☐ No
When? Year: _____ Your age: _____

If yes, explain the circumstances and any problems you had afterwards:

_____

_____

_____

Describe your recent mood: _____
Have you been involved in psychological or psychiatric treatment? ☐ Yes ☐ No
With whom? _____ When?_____
Who suggested the treatment? _____
For what were you treated? _____
[SI/HI AH/VH]

ALCOHOL INTAKE:
My last drink was: ☐ less than 24 hours ago ☐ 24-48 hours ago ☐ over 48 hours ago
_____ Beverages per week/month
_____ % drink to intoxication

Period of heavy drinking: Years: _____
_____ Beverages per week/month _____ % drink to intoxication

TOBACCO/DRUG INTAKE:
Do you have a history of tobacco use? ☐ Yes ☐ No Current Smoker? ☐ Yes ☐ No
Type of tobacco used: _____ Amount/Number per day: _____

Do you have a history of illicit substance use? ☐ Yes ☐ No
Type/s of drug used: _____
Frequency of use: _____

SLEEP/APPETITE/SEXUAL INTEREST/EXERCISE:
Describe your recent sleep: _____
Insomnia: ☐ Early Phase ☐ Middle Phase ☐ Late Phase

Describe your recent appetite: _____ Recent weight loss/weight gain? _____
Have there been any recent changes in your sexual interest? _____

Describe your exercise routine:_____

Please list any medications, vitamins, or supplements you are currently taking (over-the-counter or prescription medication, and the schedule and dosage, if known):

a) _____
b) _____
c) _____
d) _____
e) _____
f) _____
g) _____
h) _____
i) _____
j) _____

FAMILY HISTORY:

Where were you born? _____
Where were you raised? _____ Until what year? _____
How many siblings do you have, and what medical/learning conditions have they experienced?

Name	**Male/Female (circle)**	**Age**	**Conditions**
	M / F		
	M / F		
	M / F		
	M / F		
	M / F		
	M / F		

Describe any medical or psychological conditions that run in your family (and in what family member):

_____
_____
_____
_____

[PD HD AD Scz Ep MS LU]

Do you live alone or with others? (if with others, whom?): _____
Current marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Number of children: _____
_____
_____

ACTIVITIES OF DAILY LIVING: Describe any problems completing normal activities of living: ___
_____
_____
_____
_____

HOBBIES: _____

DRIVING:
Do you hold a valid driver's license? ☐ Yes ☐ No Do you currently drive? ☐ Yes ☐ No
Have you been involved in any car accidents? ☐ Yes ☐ No
Explain: _____
_____

LEGAL: Do you have a history of past or current legal involvement? ☐ Yes ☐ No
Explain: _____

EDUCATIONAL HISTORY:
High Sch: Yr. Graduated _____ Location:_____
College: Yr. Graduated _____ Location:_____Disc.:_____
Yr. Graduated _____ Location:_____Disc.:_____
Yr. Graduated _____ Location:_____Disc.:_____

Graduate: Yr. Graduated _____ Location:_____Disc.:_____
Yr. Graduated _____ Location:_____Disc.:_____

1) Describe your usual performance as a student:
☐ A&B ☐ B&C ☐ C&D ☐ D&F

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

2) What was your strongest subject(s)? _____
3) What was your weakest subject(s)? _____

Please **rate** your abilities in the following (excellent, poor, fair, etc.):
Spelling _____ Reading _____ Arithmetic _____

4) Did you ever repeat a grade?
If yes, what grade(s)? _____ and reason? _____

5) Were you ever in any special class(es) or did you receive special services for learning difficulties? ___
_____
6) Have you ever had an evaluation before today? _____
_____

MILITARY HISTORY:
Have you served in the military? ☐ Yes ☐ No If yes, what branch? _____
Years served: _____ Highest rank earned: _____
Type of discharge: _____

OCCUPATIONAL HISTORY:
1) Job title of patient (if working): _____ Year Retired: _____
School attending (if student): _____ Major: _____

2) How long have you been at your current job? _____
Past Jobs:
Position: _____ Years: _____
Position: _____ Years: _____
Position: _____ Years: _____
Position: _____ Years: _____
Position: _____ Years: _____
Position: _____ Years: _____