

HUFFMAN PSYCHOLOGY, PLLC

Jennifer L. Huffman, Ph.D., ABPP-CN and Associates
Clinical Psychology and Neuropsychology Services

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):

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Head injury | <input type="checkbox"/> Behavioral problems |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Psychological problems |

Other problems: _____



MEDICAL HISTORY:

Medical illnesses as a child: _____

Medical illnesses as an adult: _____

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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:

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

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

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? _____

ALCOHOL INTAKE:

_____ Beverages per week/month

_____ % drink to intoxication

Period of heavy drinking: Years: _____

_____ Beverages per week/month

_____ % drink to intoxication

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

TOBACCO/DRUG INTAKE:

Do you have a history of tobacco use? Yes No

Type of tobacco used: _____ 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:

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? _____

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: _____

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: _____

MILITARY HISTORY:

Have you served in the military? Yes No If yes, what branch? _____

Years served: _____ Highest rank earned: _____

Type of discharge: _____

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.: _____

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? _____

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: _____

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

