S. W. ZIMOSTRAD, Ph.D. AND ASSOCIATES

CLINICAL AND BEHAVIORAL NEUROPSYCHOLOGY

720 W. Wackerly St., Midland, MI 48640 *Ph: 989.839.6565* Fax: 989-839-5794 * 4957 W. M-72, Grayling, MI 49738

ADULT HISTORY FORM

Greetings new patient. Please take some time to complete this form **in its entirety**. Your responses to the following questions are very important and will allow us to gain a better understanding of you and any current problems. We are aware that it may be difficult to remember certain dates and events – In such instances, please provide your best estimate.

– Please answer every question –

Name: _____ Date: _____

Address: _____

Telephone: Home: _____ Work: _____

Date of Birth: _____ Current Age: _____ Sex: _____

Do you have a legally appointed guardian? (If yes, give a full name, address, and telephone number)

_____

_____

Family Doctor: _____ **Telephone:** _____

Address: _____

Are you currently being seen by any other doctors? ❑ Yes ❑ No
If so, please provide:

Name: _____ Telephone: _____

Address: _____

Name: _____ Telephone: _____

Address: _____

Do you have a case manager? ❑ Yes ❑ No
If so, please provide:

Name: _____ Telephone: _____

Address: _____

Who referred you to our Office?

Name: _____ Telephone: _____

Address: _____

Please clearly describe your current reasons for seeking an evaluation:

_____

_____

_____

_____

Please describe your current symptoms:

_____

_____

_____

_____

Where do these symptoms affect you the most?

- ❑ Home
- ❑ School
- ❑ Work
- ❑ All of the above

When did your current symptoms and/or concerns first start?

_____

_____

_____

Does anyone else in your family have these same problems? Have any family members in the past had these same problems?

❑ Yes ❑ No

If so, please state who:

_____

DEVELOPMENTAL HISTORY

Are you aware of any developmental delays as a child? (For example: early problems walking or talking?)

❑ Yes ❑ No

If yes, please describe:

_____

Did you have any serious injuries or illnesses as an infant or child?

❑ Yes ❑ No

If yes, please describe:

_____

_____

_____

MEDICAL HISTORY

Do you have any medical conditions?

❑ Yes ❑ No

If yes, please describe:

Condition: _____ What year were you diagnosed? _____

❒ Resolved ❒ Ongoing

Condition: _____ What year were you diagnosed? _____

❒ Resolved ❒ Ongoing

Condition: _____ What year were you diagnosed? _____

❒ Resolved ❒ Ongoing

Condition: _____ What year were you diagnosed? _____

❒ Resolved ❒ Ongoing

Condition: _____ What year were you diagnosed? _____

❒ Resolved ❒ Ongoing

Have you ever had a head injury? (Including concussions, traumatic brain injuries, skull fractures, brain swelling etc.)

❑ Yes ❑ No

If yes, please indicate the following:

Type of head injury: _____ Year of the Injury: _____
Were you medically evaluated following the head injury?
❑ Yes ❑ No

Type of head injury: _____ Year of the Injury: _____
Were you medically evaluated following the head injury?
❑ Yes ❑ No

Type of head injury: _____ Year of the Injury: _____
Were you medically evaluated following the head injury?
❑ Yes ❑ No

Type of head injury: _____ Year of the Injury: _____
Were you medically evaluated following the head injury?
❑ Yes ❑ No

Have you ever had any of the following procedures?

❑ MRI Year _____ Results: _____

❑ CT Scan Year _____ Results: _____

❑ EEG Year _____ Results: _____

❑ PET Scan Year _____ Results: _____

❑ MEG Scan Year _____ Results: _____

Please List any medications that you are currently taking:

Medication: _____ Year prescribed: _____

Medication: _____ Year prescribed: _____

Medication: _____ Year prescribed: _____

Medication: _____ Year prescribed: _____

Medication: _____ Year prescribed: _____

Medication: _____ Year prescribed: _____

Medication: _____ Year prescribed: _____

What is your appetite like? (please check the appropriate boxes)

- ❑ My appetite is generally good – No major changes
- ❑ My appetite is generally poor – I don't eat very much
- ❑ My appetite changes a lot – Sometimes I eat well, other times I don't eat very much

What is your sleep like? (please check the appropriate boxes)

- ❑ I have problems getting to sleep These problems started in (year): _____
- ❑ I have problems staying asleep These problems started in (year): _____
- ❑ I have no current sleep problems – I generally sleep well.

Do you have any hearing or vision problems?

- ❑ Yes, I wear hearing aids
- ❑ Yes, but I don't have hearing aids
- ❑ No, my hearing is fine
- ❑ Yes, I wear glasses
- ❑ Yes, but I don't have glasses
- ❑ No, my vision is fine

EDUCATION AND EMPLOYMENT HISTORY

Years of school (please circle): 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

Did/do you have any of the following problems while in school?

- ❑ Problems paying attention
- ❑ Problems turning in work
- ❑ Problems with organization
- ❑ Hyperactive
- ❑ Problems with teachers
- ❑ Learning problems
- ❑ Behavior problems
- ❑ Problems with other students

Were you in any special education classes in school?

❑ Yes ❑ No

Were you ever held back a grade?

❑ Yes ❑ No

If yes, which grade(s) were you held back in? _____

High school GPA _____ College GPA _____

If you graduated from college/graduate school, what was your major? _____

Are you currently employed?

❑ Yes ❑ No ❑ Retired

If yes: (If no or retired, please indicate your previous employment)

Where: _____ How Long have/did you worked here? _____

What is/was your job title? _____

SOCIAL HISTORY

Are you:

❑ Currently married ❑ Single ❑ Divorced Finalized in _____ ❑ Widowed

Check the box or boxes that best describe your current living situation

❑ Currently living alone

❑ Currently living with spouse or significant other

❑ Currently living with roommate

❑ Other (please explain): _____

Do you have children? ❑ Yes ❑ No

If yes, please indicate the following:

Age _____ ❑ Male ❑ Female

Age _____ ❑ Male ❑ Female

Age _____ ❑ Male ❑ Female

Age _____ ❑ Male ❑ Female

Age _____ ❑ Male ❑ Female

Do YOU have siblings? ❑ Yes ❑ No

If yes, please indicate the following:

Age _____ ❑ Male ❑ Female

Age _____ ❑ Male ❑ Female

Age _____ ❑ Male ❑ Female

Age _____ ❑ Male ❑ Female

Age _____ ❑ Male ❑ Female

Is there any <u>family</u> history of the following conditions? (check all that apply)

❑ Alzheimer's……In who? _____

❑ Dementia……In who? _____

❑ Parkinson's Disease……...In who? _____

❑ Huntington's Disease……In who? _____

❑ Pick's Disease……In who? _____

❑ Depression……..In who? _____

❑ Anxiety……...In who? _____

❑ ADD/ADHD……..In who? _____

❑ Schizophrenia……In who? _____

❑ Bipolar Disorder……In who? _____

Please Describe your relationships with family members (any strained relationships?)

_____

_____

_____

_____

_____

Are you currently experiencing stress due to family problems, work-related problems, finances, traumatic events, or other causes? (if so, please describe)

_____

_____

_____

_____

What do you do for fun? (leisure activities, hobbies, interests)

_____

_____

MENTAL HEALTH HISTORY

Have you ever been hospitalized for psychological/psychiatric reasons? ❑ Yes ❑ No

If yes, please indicate the following:

Where: _____ When (year) _____ How long? _____

Where: _____ When (year) _____ How long? _____

Where: _____ When (year) _____ How long? _____

Have you ever had a psychological or neuropsychological evaluation before? ❑ Yes ❑ No

Have you ever been diagnosed with any of the following conditions:

❑ Depression ❑ Learning problems ❑ Bipolar Disorder

❑ Anxiety ❑ Obsessive Compulsive Disorder ❑ Anorexia or Bulimia

❑ ADD/ADHD ❑ PTSD (Post-Traumatic stress Disorder)

❑ Schizophrenia ❑ Borderline Personality Disorder

Are you currently seeing/working with a counselor or therapist? ❑ Yes ❑ No

If so, please provide:

Name: _____ Telephone: _____

Address: _____

If yes, how long have you been seeing this therapist? _____

If yes, has this therapy been helpful? _____

SUBSTANCE USE AND LEGAL HISTORY

Do you now, or have you previously used alcohol? ❑ Yes ❑ No

At what age did you begin begin using alcohol? _____

What do you drink? (e.g., beer, liquor, wine) _____

About how many drinks do you have during an average week? _____

Do you use tobacco? ❑ Yes ❑ No **Any other drugs?** ❑ Yes ❑ No

If so, please list: _____

Have you ever been arrested? ❑ Yes ❑ No

If yes, please explain: _____

Are you currently involved in any legal proceedings or law suits? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

_____

Do you have an active driver's license? ❑ Yes ❑ No

Has your driver's license ever been suspended or revoked? ❑ Yes ❑ No

If yes, please explain why: _____

END

Thank you for taking the time to respond to these questions. Your feedback and information is important, and will help us better understand any current problems that you may be experiencing. Please return this completed form to the receptionist.