12625 High Bluff Dr., Ste. 202
San Diego, CA 92130
(858) 481-4988 Fax (858) 792-5095

Date_____
Name_____

ADULT HISTORY

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Now	Past		Now	Past	
____	____	Suicidal thoughts	____	____	Homicidal thoughts
____	____	Depression/sadness	____	____	Anxiety/nervousness
____	____	Recurrent/intrusive thoughts	____	____	Nightmares
____	____	Difficulty sleeping	____	____	Loss of appetite
____	____	Overeating	____	____	Weight loss
____	____	Weight gain	____	____	Sexual problems
____	____	Visual/auditory hallucinations	____	____	Apathy
____	____	Anorexia/Bulimia	____	____	Explosive anger
____	____	Rapid mood changes	____	____	Euphoria (feel on top of the world)
____	____	Decreased need for sleep	____	____	Racing thoughts
____	____	Distractible	____	____	Feeling worthless
____	____	Fatigue	____	____	Loss of interest in almost all activities
____	____	Poor self esteem	____	____	Feelings of hopelessness
____	____	Overwhelming need to perform certain behaviors/rituals	____	____	Recurrent/intrusive disturbing recollections or dreams
____	____	Significant concerns with physical problems	____	____	Excessive fears or phobias
			____	____	Other problems:

_____

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
____	____	Death of spouse	____	____	Death of family member	____	____	Illness of family member
____	____	Illness of friend	____	____	Personal injury/illness	____	____	Marital difficulties
____	____	Marital separation	____	____	Divorce	____	____	Sexual difficulties
____	____	Conflicts with family	____	____	Conflicts with friends	____	____	Conflicts at work
____	____	New job	____	____	Job termination	____	____	Retirement
____	____	Business difficulties	____	____	Academic difficulties	____	____	Financial problems
____	____	Change in residence	____	____	Legal problems	____	____	Sexual assault
____	____	Incest/sexual abuse	____	____	Physical abuse	____	____	Verbal/emotional abuse
____	____	Other problems: _____						

Are you currently receiving therapy?_____ From who?_____
When did you start therapy?_____ For what problems(s)?_____
_____
_____

List current psychiatric medications:_____
Have you received therapy in the past?_____ From who?_____
When (Start and finish):_____ For what problem(s)?_____
_____
_____

List past psychiatric medications:_____
Have you been hospitalized for psychological problems?_____ When?_____
Where were you hospitalized?_____

Have you ever attempted suicide?_____ When?_____
How?_____

Circle substances you currently use (Even if only occasionally or in small amounts):
Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers
Amphetamines ("Speed") Crank Crack Cocaine Opiates (Heroine, Opium, Codeine, etc.)
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust") Other: _____

Circle substances you have taken in the past (Even if only occasionally or in small amounts):
Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers
Amphetamines ("Speed") Crank Crack Cocaine Opiates (Heroine, Opium, Codeine, etc.)
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust" Other:_____

Have you had a prior psychological or neuropsychological evaluation? Yes ___ No ___ If yes, complete this information:
Name of psychologist: _____
Address:
_____
Phone: _____ Date of and reason for this evaluation:_____
Findings of the evaluation:
_____

DOCTORS NOTES

Birth and Developmental History

Place of Birth:_____ Were parents married at time of birth?_____
Was mother under a doctors care during the pregnancy?_____ Was the child adopted?_____ If so, at what age?_____

Circle any illnesses during pregnancy:
Anemia Toxemia Herpes Measles German measles Bleeding
Kidney disease Heart disease Hypertension Abdominal trauma Infection Diabetes
Medications taken during pregnancy:_____
Were drugs or alcohol taken during pregnancy? Yes ___ No ___ If yes, specify:_____
Was there significant emotional stress during pregnancy? Yes ___ No ___ If yes, name stressors:
_____
Was the birth: On time ___ Premature ___ (By how long _____) Late ___ (By how long _____)
Was labor: Spontaneous ___ Induced ___ Duration of labor_____ (Hours) Cesarean required?_____
Was the presentation: Normal ___ Breach ___ Transverse (Crosswise) ___ Posterior first ___
Did the baby experience any of these problems: Fetal distress ___ Prolapsed cord ___ Low placenta (Placenta previa)
Premature separation of the placenta (Abruptio placenta) ___ Cord wrapped around neck ___

Any other problems that mother or child had:
_____
Was general anesthesia used?_____ Were forceps used?_____ Were there breathing problems?_____
Birthweight:_____ Length:_____

Circle those that apply to the first few weeks after birth:
Excessive sleeping Laziness Irritability Excessive crying Stiffness Limpness Tremors Twitching
Feeding difficulties Vomiting Jaundice
Other_____
Transfusions required?_____ Medication required? (For what)_____ Surgery required? (For what)_____

Give approximate ages that developmental milestones were achieved:
Head control_____ Rolled over_____ Sat alone_____ Walked_____ Run_____
Said first word_____ Used sentences_____ Self feeding w/ utensils_____ Toilet trained_____
Dress self_____ Tie shoes_____ Color within lines_____

Circle any problems that occurred in later development:
Hearing Speaking Stuttering Reading Writing Spelling Arithmetic Behavior Hyperactivity
Attentional difficulties Seizures Coordination

List family members with developmental or learning
problems:_____

Medical History
Please check all the conditions that have been diagnosed as a child or an adult.

___ AIDS, ARC or HIV+	___ Diabetes	___ Immune system disease	___ Poisoning
___ Allergies	___ Enzyme deficiency	___ Jaundice	___ Polio
___ Arthritis	___ Encephalitis	___ Kidney problems	___ Parkinson's Disease
___ Asthma	___ Ear Infections	___ Liver disorder	___ Rheumatic Fever
___ Abscessed ears	___ Fevers (104 or higher)	___ Lung disease	___ Pneumonia
___ Arteriosclerosis	___ Genetic disorder	___ Lead poisoning	___ Scarlet fever
___ Bleeding disorder	___ Head injury or concussion	___ Leukemia	___ Senility (Dementia)
___ Blood disorder	___ Heart problems	___ Metabolic disorder	___ Stroke or TIA
___ Broken bones	___ Hereditary disorder	___ Meningitis	___ Tuberculosis
___ Brain disease/infection	___ Headaches	___ Measles	___ Tumor
___ Cerebral palsy	___ Hearing problems	___ Mumps	___ Thyroid disease
___ Colds (excessive)	___ Huntington's disease	___ Malnutrition	___ Venereal disease
___ Chicken pox	___ Hypertension	___ Multiple sclerosis	___ Vision problems
___ Carbon monoxide poisoning	___ Hormone problems	___ Oxygen deprivation	___ Whooping cough
___ Cancer	___ Hazardous substance exposure		

___ Other medical/physical problems_____
Have you ever been diagnosed with epilepsy or a seizure disorder Yes ___ No ___
If yes, check the one you have been diagnosed with.
PARTIAL GENERALIZED ___ UNCLASSIFIED TYPE

List any medications currently being taken (over-the-counter or prescription), and the dosage.
Medication and Dosage
1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List any medications you are ALLERGIC or sensitive to:
_____

Past Hospitalizations (When, where and for what):
_____
_____
_____

Outpatient Surgeries (When, where and for what):

_____

_____

_____

Name of family physician:_____

Address:_____Phone:_____

Date of your last medical check-up:_____

Family History

Father's Name _____ Age _____ Health Problems_____

Education _____ Occupation _____ Employer _____

Mother's Name _____ Age _____ Health Problems _____

Education _____ Occupation _____ Employer _____

Date of parent's marriage _____ Years married _____ Current marital problems? _____

If separated, give date _____ If divorced, date_____

Previous marriages? (Father)_____ (Mother)_____ Subsequent marriages? (Father)_____ (Mother)_____

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years

Names and ages of brothers and sisters (Include step-brothers and step-sisters):

_____

_____

_____

List anyone else who lived in the home during your childhood:

_____

List names of any family members (E.G. Immediate and distant relatives) with any of the following problems:

Alcohol/drug abuse

_____

Criminal history

_____

Emotional/behavioral problems

_____

Medical problems (e.g. Heart disease, Cancer, Seizures)

_____

Learning/developmental problems

_____

DOCTORS NOTES

Marital History
Marital Status: Single Married Separated Divorced Widowed

Current Marriage
Date of marriage:_____ Number of years married:_____ Date of separation:_____ Date of divorce:____
Spouse's name: _____ Age:_____ Health: _____
Education: _____ Occupation: _____
Type of marital problems:
_____
Names and ages of children:
_____
If divorced/separated, what is the custody arrangement:
_____

Prior Marriage
Date of marriage:_____ Number of years married:_____ Date of separation:_____ Date of divorce:_____
Spouse's name: _____ Age:_____ Health: _____
Education: _____ Occupation:
_____
Type of marital problems:
_____
Names and ages of children:
_____
If divorced/separated, what is the custody arrangement:
_____

Prior Marriage
Date of marriage:_____ Number of years married:_____ Date of separation:_____ Date of divorce:_____
Spouse's name: _____ Age:_____ Health: _____
Education: _____ Occupation_____
Type of marital problems:
_____
Names and ages of children:
_____
If divorced/separated, what is the custody arrangement:
_____
List any other marriages and children:
_____
_____

List names of spouses or children with the following problems:
Developmental/Learning problems:
_____
Emotional/Behavioral problems:
_____
Alcohol/Drug abuse:
_____
Medical problems:
_____

DOCTORS NOTES

Social History
If single or separated, are you currently dating anyone? _____ How long? _____ Is it a serious relationship? _____
First name: _____ Are you currently sexually active? _____ If not dating, when was your last date?____
How long did you date that person? _____ Was it a serious relationship? _____ First name:_____

Please list "significant others" you have lived with but not married.
Current/Most Recent Cohabitation
Date began:_____ Number of years together:_____ Date ended:_____
Name :_____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems:_____ _____
Names and ages of children: _____
If separated, what is the custody arrangement:
_____

Prior Cohabitation
Date began:_____ Number of years together:_____ Date ended:_____
Name :_____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems:_____
Names and ages of children: _____
If separated, what is the custody arrangement:
_____
Have you lived with anyone else in the past? ____ Yes ____ No How many times? _____
Any other children outside of marriage? ____ Yes ____ No
Names/Ages:_____
Any aborted pregnancies/miscarriages? ____ Yes ____ No When? _____

List clubs and community/business organizations you are involved with and how often you attend:
_____
_____
Do you attend church/Temple? (where and how often)
_____
What do you do with your free time (including hobbies and extracurricular interests):
_____
_____
When was your last vacation (Please
describe):_____
_____

How many close friends do you have in the community:_____ How often do you get together with friends or family:
_____
How long have you lived in the community:_____ Where have you lived in the past: _____

Educational History
Current grade (Or highest grade/degree completed): _____ Current school: _____
Past schools attended (List in order):
_____
_____

Hardest subject(s): _____ Favorite subject(s): _____
Grades earned in elementary school: _____ Junior High G.P.A _____ High School G.P.A._____
College GPA _____ Grades repeated: _____

Learning problems (what subjects):
_____

Special education placement (Type): _____ During which grades: _____
Extracurricular activities (Music, Sports, Clubs, etc.)

_____
Expulsions/suspensions/conduct problems (Type of problem and date):

_____
Additional schooling or non-academic training:

_____

Occupational History
Present employer: _____ Position: _____
Length of employment: _____ Hours worked per week _____
Current responsibilities: _____
List previous employment for last ten years (Include dates and type of work):

_____
_____
_____
_____
_____

Have you ever been terminated from a job (Please explain):_____

_____

At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)?
Yes ___ No ___ If yes, explain: _____
Have you ever been injured on the job? Yes ___ No ___ If yes, explain: _____

DOCTORS NOTES

Legal History
Present legal problems (Describe):

_____
Past arrests (For what?):

_____
Convictions (For what?):

_____
Time served in juvenile hall, jail or prison (Give dates and locations):

_____

Military Service
Branch of service: _____ Dates of service: _____
Job(s) within service:

_____
Highest rank: _____ Rank at discharge: _____ Discharge status: _____
Were you exposed to any dangerous or unusual substances (e.g. Agent Orange, Radiation, etc.) Yes ___ No ___
If yes, explain:

_____
Did you sustain any physical injuries in the military? Yes ___ No ___ If yes, explain:

_____