ADULT HISTORY FORM FOR TESTING

Name: _____ Age: _____ DOB: _____

Phone #: _____ Email Address: _____

What are the difficulties that led you to seek an evaluation? _____

_____

_____

_____

What are your strengths? _____

_____

_____

FAMILY HISTORY

Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Who do you live with? _____

_____

Who did you grow up living with? _____

_____

What language(s) do you speak? _____

Please describe any <u>suspected or diagnosed</u> developmental, learning (e.g., repeated grades, 504/IEP), behavioral, psychological, or medical difficulties amongst your biological parents, siblings, & children:

_____

_____

_____

_____

_____

_____

_____

Please describe any suspected or diagnosed developmental, learning, behavioral, psychological, or medical difficulties among extended biological family members (uncles, aunts, cousins, grandparents):

Maternal/mother's side	Paternal/father's side
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

BIRTH & DEVELOPMENTAL HISTORY

Any illnesses or complications during pregnancy? ❒Yes ❒ No

If yes, please explain: _____

_____

Any medications/substances used during pregnancy? ❒ Yes ❒No

If yes, please list: _____

Any complications during labor or delivery? ❒ Yes ❒ No

If yes, please explain: _____

_____

_____

Full Term? ❒ Yes ❒ No: _____weeks gestation

❒ Vaginal ❒ C-section Birth weight: _____lbs. _____ oz.

Did you require special interventions or care at birth (e.g., light therapy, NICU)? ❒ Yes ❒ No

If yes, please explain: _____

_____

_____

Any delays in when you began walking? ❒ Yes ❒ No

Any delays in when you began talking? ❒ Yes ❒ No

Did anyone indicate concerns about your development? ❒ Yes ❒ No

If yes, please explain: _____

_____

Have you ever received: ❒ Speech Therapy ❒ Physical Therapy ❒ Other

❒ Occupational Therapy ❒ Regional Center Services

If yes:

Age(s) (e.g., from 8 to 10)	Duration (e.g., 30 min)	Frequency (e.g., 2x/week)	What was the treatment for?

MEDICAL HISTORY

Do you or others have concerns about your appetite or eating habits? ❒ Yes ❒ No

If yes, please describe: _____

_____

_____

_____

Do you have difficulty with: ❒ falling asleep ❒ staying asleep ❒ nightmares

How many hours of sleep do you get per night? _____

Do you wear/use any adaptive devices (e.g., walker, hearing aids, glasses/contacts)? ❒ Yes ❒ No

If yes, please describe: _____

_____

_____

Do you or others have concerns for your hearing? ❒ Yes ❒ No

Do you or others have concerns for your vision? ❒ Yes ❒ No

Have you ever had a head injury or lost consciousness (LOC)? ❒ Yes ❒ No

If yes, please describe, including duration of LOC and at what age: _____

_____

_____

Have you ever been to the emergency room, been hospitalized, or had surgery? ❒ Yes ❒ No

If yes, please describe condition/injury/surgery, treatment, duration, and at what age:

_____

_____

_____

Please describe any other medical conditions, diagnoses, health considerations, and/or treatments:

_____

_____

_____

_____

_____

_____

Please list current and past medications or supplements:

Name	Current Dose	Date Started	Date Ended	Side Effects?

Any difficulties taking medication(s)? ❒ Yes ❒ No

PSYCHIATRIC HISTORY

Do you have current difficulty with: ❒ attention/focus ❒ hyperactivity ❒impulsivity

❒ memory ❒ organization ❒ regulating emotions ❒ anxiety/depression

❒ risky behaviors ❒ making/keeping friends ❒ interacting with others

How would you describe your mood, most days? _____

_____

Have you ever received a psychological, neuropsychological, or psychoeducational evaluation before?

❒ Yes ❒ No *(*If yes, please provide copy to examiner)*

If yes, please describe type of professional who did the assessment and age at evaluation:

_____

_____

Have you ever been diagnosed with a mental health condition? ❒ Yes ❒ No

If yes:

Diagnosis Name *(e.g., ADHD)*	Date Diagnosed	Who Diagnosed? *(psychiatrist, therapist, pediatrician, etc.)*

Are you currently in therapy? ❒ Yes ❒ No

Have you ever been in therapy? ❒ Yes ❒No

Date Began	Date Ended	Frequency *(e.g., 50 min, 1x/week)*	What was the therapy for?

Have you experienced any unusual, traumatic, or possibly stressful events, either in the past or recently?

❒ Yes ❒ No

If yes, please describe: _____

_____

_____

_____

ACADEMIC HISTORY

What is your highest level of education:

❒ High School ❒ Some College ❒ Completed College (BA/BS) ❒ Graduate School (PhD, MD, JD, etc.)

Have you ever: ❒ Skipped a grade: _____ ❒ Repeated a grade: _____

Do you have current difficulty with:

❒ Reading fluency ❒ Reading comprehension ❒ Mathematics

❒Spelling ❒ Written expression ❒ Handwriting

Have you ever had tutoring? ❒ Yes ❒ No

If yes, please describe in what subject areas and when (ages/grades): _____

_____

_____

_____

Have you ever had a 504 Plan, IEP, or other classroom/learning supports? ❒ Yes ❒ No

*(*If yes, please provide copy of current/prior plans to examiner)*

Please list previous schools and grades attended at each, starting at preschool:

School	Grades Attended	Grades Received *(e.g., A's-F's, 1-4's)*	Teacher(s) Have Concerns? *If yes, please describe.*

OCCUPATIONAL HISTORY

Please list all current and former jobs, dates of employment, responsibilities, and any difficulties completing your work and/or concerns from management.

Job Title	Dates of Employment	Job Responsibilities	Issues/Concerns? *If yes, please describe.*

SOCIAL HISTORY

Please list your hobbies: _____

_____

_____

_____

Do you have friends? Please describe your social support network, how you gets along with others, and any concerns:

_____

_____

_____

_____

Do you currently: ❒ Smoke/Vape ❒ Drink Alcohol ❒ Use other substances