

**ADD AUSTIN
HISTORY QUESTIONNAIRE: ADULTS 18+**

Name _____ Today's date _____ Date of birth _____ Age _____

Marital status (circle one): single married divorced widowed live-in partner other _____

Handedness (circle one): right left ambidextrous

Are any of your blood relatives left-handed or ambidextrous? Yes No If yes, who? _____

Please list all current medications and dosages (include non-prescription drugs & supplements):

Briefly describe the concerns or problems that bring you here:

When did these first occur? _____

Has there been any change over time (better? worse?) _____

How are these problems affecting you at home? _____

At work or school? _____

In relationships? _____

In other areas? _____

DEVELOPMENTAL, EDUCATIONAL, & OCCUPATIONAL HISTORY

Were there any medical complications when your mother was pregnant with you? Yes No Don't know

If yes, please describe? _____

Were you born prematurely? Yes No If yes, how many weeks? _____

Complications at birth? Yes No If yes, explain _____

Birth weight: _____ Age at which you began: to walk _____ to talk _____

What is your highest level of education? _____

Were you held back in school? Yes No If yes, what grade(s)? _____

Did you have tutoring in school? Yes No If yes, in what subject(s)? _____

Were you placed in special classes? Yes No If yes, when? _____

Name: _____

Did you have speech therapy? Yes No If yes, at what age? _____

Place a check by those subjects with which you had difficulties:

Reading _____ Math _____ History _____
Writing _____ Art _____ Foreign Lang. _____
Spelling _____ Gym _____ Other: _____

What were your best or strongest subjects? _____

Were you ever told that you have a learning disability? Yes No If yes, what type? _____

Did you have motor coordination problems? Yes No Describe: _____

Were you considered to be a discipline problem in school? Yes No If yes, how so? _____

Elementary education (circle one): private public combination Grades/Marks: _____

High school education (circle one): private public combination Grades/Marks: _____

How old were you when you finished high school (or left school)? _____

If you attended college or trade school, what school(s) did you attend? _____

Your major? _____ Your grade point average? _____ Did you graduate? _____

If you attended graduate, professional, or trade school, where did you go? _____

What was your field of study? _____

Did you complete your degree? Yes No What was your GPA? _____

Are you currently employed? Yes No Retired If yes, how long at this job? _____

If yes, please describe your work: _____

If no, what was the nature of the last job you had? _____

If retired, when? _____

What other kinds of work have you done? _____

Did you serve in the military? Yes No If so, dates & branch of service: _____

MEDICAL HISTORY

Please list any current/active medical problems: _____

When was your last medical checkup? _____

Please indicate whether you currently use any of the following:

Alcohol? Yes No If yes, how much in an average week? _____
Caffeine? Yes No If yes, how much in an average day? _____
Tobacco? Yes No If yes, how much in an average day? _____
Marijuana? Yes No If yes, how much in an average week? _____
Other street drugs? Yes No If yes, which ones & how often? _____

Have you ever been told you have a problem with alcohol or drugs? Yes No If yes, describe: _____

Please indicate whether you have a problem with any of the following:

Sleep? Yes No Describe: _____
Appetite? Yes No Describe: _____
Weight? Yes No Describe: _____
Sex drive? Yes No Describe: _____

Name: _____

Please list any past major illnesses, injuries, or surgeries:

| Illness/Injury/Surgery | Age at onset |
|------------------------|--------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Have you ever had a head injury? Yes No If yes, describe _____

Did you lose consciousness? Yes No

Were you treated medically? Yes No

Do you have headaches? Yes No If yes, describe: _____

Have you ever had a seizure? Yes No If yes, describe: _____

Have you been exposed to toxins? Yes No If yes, describe: _____

Have you been tested for AIDS/HIV? Yes No If yes, was it positive? _____

PLEASE INDICATE WHETHER YOU HAVE (OR HAD) A PROBLEM WITH ANY OF THE FOLLOWING:

Cognition:

- ___ Memory _____
- ___ Episodes of confusion _____
- ___ Speech _____
- ___ Reading _____
- ___ Writing _____
- ___ Spelling _____
- ___ Reading maps _____
- ___ Right/left confusion _____
- ___ Getting lost _____
- ___ Attention/Concentration _____
- ___ Daytime sleepiness _____

Sensorimotor:

- ___ Eyes/Vision _____
- ___ Ears/Hearing _____
- ___ Taste _____
- ___ Smell _____
- ___ Dizziness/Vertigo _____
- ___ Balance _____
- ___ Coordination _____
- ___ Walking _____
- ___ Numbness/Tingling _____
- ___ Focal weakness _____
- ___ Tremors or Tics _____
- ___ Hyperactivity _____
- ___ Fatigue _____
- ___ Muscular symptoms _____
- ___ Uncontrolled movements _____
- ___ Swallowing _____
- ___ Pain _____

Name: _____

General Health:

- ____ Allergies _____
- ____ Blood pressure _____
- ____ Heart problems _____
- ____ Chest pain _____
- ____ Anemia/blood problems _____
- ____ Diabetes _____
- ____ Vascular problems _____
- ____ Stomach or bowel _____
- ____ Liver problems _____
- ____ Kidney problems _____
- ____ Urinary problems _____
- ____ Lung problems _____
- ____ Pancreas or gall bladder _____
- ____ Thyroid/Hormones _____
- ____ Joint pain/Arthritis _____
- ____ Cancer/tumors _____
- ____ Other _____

WOMEN ONLY:

- Menstrual problems? Yes No Describe: _____
- PMS? Yes No Describe: _____
- Hysterectomy? Yes No Age? _____
- Postmenopausal? Yes No Age? _____
- Other gynecological problems? Yes No Describe: _____

MEN ONLY:

- Prostate problems? Yes No Describe: _____
- Genitourinary problems? Yes No Describe: _____

Have you ever had a brain scan? Yes No If yes, what type? (circle) MRI CT scan
When? _____ Where? _____ Why? _____
What were the results of the scan? _____

Have you ever had an EEG (brain wave)? Yes No
When? _____ Where? _____ Why? _____
What were the results of the EEG? _____

PSYCHIATRIC HISTORY

Have you ever participated in therapy before? Yes No With whom? _____
If yes, what was the experience like? _____

Have you ever taken any psychiatric medications (e.g., antidepressants)? Yes No
If yes, which ones? _____

Have you ever been hospitalized for psychiatric reasons? Yes No If yes, describe: _____

Name: _____

Have you ever experienced any of the following (check all that apply)? If unsure, use a “?”:

- _____ Racing or tangential thoughts
- _____ Intrusive or disturbing thoughts
- _____ Paranoia or the sense that others are watching you
- _____ Feelings of unreality or depersonalization (e.g., feeling outside your body)
- _____ Frequent episodes of déjà vu
- _____ Episodes of intense anxiety or fear
- _____ Panic attacks
- _____ Uncontrolled anger or violent behavior
- _____ Mood swings
- _____ Depressed mood
- _____ Suicidal thoughts
- _____ Attempted suicide
- _____ Mania or hypomania (e.g., periods of very high energy with prolonged lack of sleep)
- _____ Hallucinations (e.g., hearing voices or seeing things that others do not perceive)
- _____ Victim of physical or sexual abuse or assault _____
- _____ Compulsions (e.g., excessive hand washing; frequently checking locks)
- _____ Eating disorder _____
- _____ Self-harming behaviors without suicidal intent (e.g., cutting, burning)

FAMILY MEDICAL & PSYCHIATRIC HISTORY (Please provide complete information)

| | Current Age | Age at Death | <u>Medical</u> and <u>Psychiatric</u> History (incl alcohol/drugs) |
|----------|-------------|--------------|--|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Brothers | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

SOCIAL HISTORY

Spouse/partner’s name: _____ Age? _____ Length of relationship: _____

Previous marriages, if any: You _____ Partner _____

Names/ages of children (include step-children): _____

Were your parents divorced? ____ If yes, how old were you? _____ Which parent had custody? _____

How would you describe your relationship with your family-of-origin? _____

How would you describe your current significant relationships? _____

How would you describe your social life? _____

What kind of work did/do your parents do? Father: _____ Mother: _____ Step-parent: _____

Do you attend religious services on a regular basis? Yes No Comments: _____

What is your religious background? _____ Current preferences? _____

Do you exercise regularly? Yes No If yes, what do you do? _____

What are your interests or hobbies? _____

What are your strengths or talents? _____

Name: _____

History Questionnaire - 6

Do you have any problems driving? Yes No If yes, describe: _____

Do you talk on a cell phone while driving? Yes No

Have you ever been arrested? Yes No If yes, describe: _____

Are you currently involved in a lawsuit? Yes No If yes, describe: _____

If there is any other information that you think is important for me to know, please write it below:

Name of person who completed this form if other than the patient/client: _____

Relationship to patient/client: _____

SELF-DESCRIPTION CHECKLIST: Please check each item below that describes your *current* feelings.

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Abused | <input type="checkbox"/> Guilty | <input type="checkbox"/> Loss of self-respect |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Happy | <input type="checkbox"/> Marital/partner stress |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hopeful | <input type="checkbox"/> Neglected |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Apathetic | <input type="checkbox"/> Hurt | <input type="checkbox"/> Optimistic |
| <input type="checkbox"/> Ashamed | <input type="checkbox"/> Inadequate | <input type="checkbox"/> Outgoing |
| <input type="checkbox"/> Bereaved | <input type="checkbox"/> Indifferent | <input type="checkbox"/> Overeating |
| <input type="checkbox"/> Cheerful | <input type="checkbox"/> Irritable | <input type="checkbox"/> Panicked |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Isolated | <input type="checkbox"/> Puzzling ideas |
| <input type="checkbox"/> Dangerous | <input type="checkbox"/> Jealous | <input type="checkbox"/> Resentful |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Lonely | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Distrustful | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Spiritual worries |
| <input type="checkbox"/> Energetic | <input type="checkbox"/> Loss of faith/God | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Fatigued | <input type="checkbox"/> Loss of faith/Other | <input type="checkbox"/> Unhappy |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Loss of faith/Self | <input type="checkbox"/> Violent |
| <input type="checkbox"/> Forgotten | <input type="checkbox"/> Loss of love | <input type="checkbox"/> Work stress |
| <input type="checkbox"/> Fretful | <input type="checkbox"/> Loss of meaning | <input type="checkbox"/> Worried |

Other: _____