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Diplomate of the American Board of Psychiatry and Neurology

Child, Adolescent & Adult Psychiatry

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Adult Psychological History

Date of Appointment: _____

Name of person filling out form:_____ Relationship to patient:_____

Patient Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Social Security #:_____ Home Address: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ Employer:_____

Referred By: _____ Reason For Referral:_____

Litigation pending?_____ Attorney: _____ Phone: _____

History of Present Problem

How long ago did problems begin: _____

Please describe the problems that you want help with:_____

Psychiatric History

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

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

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
☐	☐	Incent/sexual abuse	☐	☐	Physical abuse	☐	☐	Verbal/emotional abuse
☐	☐	Other problems: _____						

Are you currently receiving therapy? ☐ Yes ☐ No From who? _____
When did you start therapy? _____ For what problems(s)? _____
_____
List current psychiatric medications: _____
Have you received therapy in the past? ☐ Yes ☐ No From who? _____
When (Start and finish): _____ For what problem(s)? _____
_____
List past psychiatric medications: _____
Have you been hospitalized for psychological problems? ☐ Yes ☐ No When? _____
Where were you hospitalized? _____
Have you ever attempted suicide? ☐ Yes ☐ No When? _____ How? _____

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: _____

Substance Use History

Current Past (Even if only occasionally or in small amounts):

☐ ☐ Alcohol What do you drink? ☐Beer ☐Wine ☐Mixed Drink ☐ Hard Liquor
How Often? _____ How Many? _____
DUI? ☐ Yes ☐ No Accidents? ☐ Yes ☐ No Missed work or school? ☐ Yes ☐ No
Risky Behavior ☐ Yes ☐ No If so, what? _____

☐ ☐ Tobacco How Much? _____ How Often? _____ When did you quit? _____
☐ ☐ Marijuana
☐ ☐ Barbiturates ("Downers")
☐ ☐ Tranquilizers
☐ ☐ Amphetamines ("Speed")
☐ ☐ Crank
☐ ☐ Crack
☐ ☐ Cocaine
☐ ☐ Opiates (Heroine, Opium, Codeine, etc.)
☐ ☐ Hallucinogenic (LSD, STP, "Magic Mushrooms", etc.)
☐ ☐ PCP ("angel dust")
☐ ☐ Ecstasy
☐ ☐ Other: _____

DOCTOR'S NOTES

Birth and Developmental History (The patient's)

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

Check 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 ☐ Cesarean planned
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: ☐ Yes ☐ No Were forceps used? ☐ Yes ☐ No Breathing problems? ☐ Yes ☐ No
Color at birth: ☐ Normal ☐ Blue ☐ Yellow Was oxygen used? ☐ Yes ☐ No (How long)? _____
APGAR Score: _____ Birthweight: _____ Length: _____

Check 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? ☐Yes ☐No Medication required? ☐Yes ☐No (Why) _____
Surgery required? ☐Yes ☐No (Why) _____

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 _____ First menstruation or beginning of puberty: _____

Check any problems that occurred in later development:

☐ Hearing ☐ Speaking ☐ Stuttering ☐ Reading ☐ Writing ☐ Spelling ☐ Arithmetic
☐ Behavior ☐ Hyperactivity ☐ Seizures ☐ Coordination ☐ Attention difficulties

List family members with developmental or learning problems: _____

DOCTOR'S NOTES

Medical History

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

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

Have you ever been diagnosed with epilepsy or a seizure disorder? ☐ Yes ☐ No If yes, check the one you have been diagnosed with.

PARTIAL
- ☐ Simple partial
- ☐ Complex partial
- ☐ Partial evolving into generalized

GENERALIZED
- ☐ Absence (Petit mal)
- ☐ Myonclonic
- ☐ Clonic
- ☐ Tonic
- ☐ Tonic-clonic (Grand mal)
- ☐ Atonic

☐ UNCLASSIFIED

Medication and dosage:

List any medications currently being taken (over-the-counter or prescription), and the 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: _____

Medical Testing

Check all medical tests that recently have been done and report any abnormal findings:

	Check here if normal	Abnormal findings
☐ Angiography	☐	_____
☐ Blood work	☐	_____
☐ Brain scan	☐	_____
☐ CT scan	☐	_____
☐ EEG	☐	_____
☐ Lumbar puncture or spinal tap	☐	_____
☐ Magnetic Resonance Imaging (MRI)	☐	_____
☐ Neurological office exam	☐	_____
☐ PET scan	☐	_____
☐ Physician's office exam	☐	_____
☐ Skull x-ray	☐	_____
☐ Ultrasound	☐	_____
☐ Other testing:_____	☐	_____

DOCTOR'S NOTES

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) _____
If divorced, current custody arrangement _____

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 biologically related family members (E.G. Immediate and distant relatives) with any of the following problems:
Alcohol Abuse _____
Criminal History: _____
Psychological/behavior problems: _____
Medical problems (e.g. Heart disease, Cancer, Seizures) _____
Learning/developmental problems: _____

DOCTOR'S 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: _____

DOCTOR'S 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? ☐Yes ☐No (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: _____

DOCTOR'S NOTES

Educational History

Current grade (Or highest grade/degree completed): _____ Current school: _____
Past schools attended (List in order): _____
Hardest subject(s): _____ Favorite subject(s): _____
Grades in elementary school: _____ Junior High G.P.A. _____ High School GPA _____ 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: _____

DOCTOR'S NOTES

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: _____

DOCTOR'S NOTES

Legal History ☐ Not Applicable

Present legal problems (Describe): _____
Past arrests (For what?): _____
Convictions (For what?): _____
Time served in juvenile hall, jail or prison (Give dates and locations): _____

DOCTOR'S NOTES

Military Service ☐ Not Applicable

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: _____

DOCTOR'S NOTES