Saasha Sutera, Ph.D.

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

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? _____ In school now? Yes No

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? _____

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/are 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 attend(ed) college or trade school, what school(s) did you attend/are you attending?
_____

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

If you are currently in school, when will you graduate? _____

If you attended graduate or professional 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 <u>current/active</u> 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: _____ History Questionnaire - 3

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 ever had Lyme Disease? 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 _____

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 _____

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: _____

_____

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 <u>complete</u> 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 <u>regularly</u>? Yes No If yes, what do you do? _____

What are your interests or hobbies? _____

What are your strengths or talents? _____

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

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

Do you text 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.

___Abused	___Guilty	___Loss of self-respect
___Ambitious	___Happy	___Marital/partner stress
___Angry	___Hopeful	___Neglected
___Anxious	___Hopeless	___Numb
___Apathetic	___Hurt	___Optimistic
___Ashamed	___Inadequate	___Outgoing
___Bereaved	___Indifferent	___Overeating
___Cheerful	___Irritable	___Panicked
___Confused	___Isolated	___Puzzling ideas
___Dangerous	___Jealous	___Resentful
___Depressed	___Lonely	___Sad
___Distrustful	___Loss of control	___Spiritual worries
___Energetic	___Loss of faith/God	___Suicidal
___Fatigued	___Loss of faith/Other	___Unhappy
___Fearful	___Loss of faith/Self	___Violent
___Forgotten	___Loss of love	___Work stress
___Fretful	___Loss of meaning	___Worried

Other: _____