Triangle Center for Behavioral Health
Lisa Ahern, Ph.D., PLLC
Adult History Questionnaire

Patient Name:______________________________ Age:________ Today's Date:___/___/___

Biological Sex:________ Identified Gender/Pronouns:________________

Birthdate:____________________ Race:_______________________

Address:____

City:_________________ State/Province:________ Zip/Postal Code:_____________

Work/Mobile Phone:________________________ Home Phone:_______________________

Ok to leave a message? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Ok to send text reminders? ☐ Yes ☐ No

Email Address: __________________________________

Please briefly state your concerns that led to you to arrange an evaluation:

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Who referred you here?

Name:______________________________ Address:____

Phone number:______________________

Family Information:

Relationship Status (circle): single married long-term relationship divorced widowed
other (explain): ___________________________

Who lives in the home with you?:

Name/Age/Relation:________________________ Name/Age/Relation:__________________________

Name/Age/Relation:________________________ Name/Age/Relation:__________________________

Name/Age/Relation:________________________ Name/Age/Relation:__________________________

Immediate family outside of the home?:

Name/Age/Relation:________________________ Name/Age/Relation:__________________________

Name/Age/Relation:________________________ Name/Age/Relation:__________________________

Developmental History: Please answer the following questions about yourself.

Were there any problems with your mother's pregnancy with you or with your birth that you know of? Explain:

____

____

What were you like as an infant/toddler (if you know)?:

Motor Development (Sitting, Walking)	☐ Normal	☐ Fast	☐ Slow
Speech and Language	☐ Normal	☐ Fast	☐ Slow
Self-help Skills (dressing, toileting, hygiene)	☐ Normal	☐ Fast	☐ Slow
Handedness	☐ Right	☐ Left	☐ Both
Toilet Trained:	☐ Normal	☐ Fast	☐ Slow

Comments: ____

Check all that apply to you as an infant/toddler/preschooler (if you know):

Activity:	Emotional:	Interpersonal:
☐ Rocking/Head banging	☐ Shy or timid	☐ Affectionate
☐ Impulsive	☐ Fearful	☐ Distant/Hard to engage
☐ Daredevil	☐ Cautious	☐ More interested in things than in people
☐ Temper outbursts	☐ Happy	☐ Slow to warm up
☐ Overactive	☐ Curious	☐ Aggressive
☐ Into everything	☐ Irritable	☐ Clingy
☐ Easy to manage	☐ Sad	☐ Stubborn
☐ Hard on belongings		☐ Independent

Medical History

Have you had any of the following?

	No	Yes	Date/Age/Description
Measles, Mumps, Rubella	☐	☐	____________________
Migraine	☐	☐	____________________
Severe Abdominal Pain	☐	☐	____________________
Cancer	☐	☐	____________________
Chicken Pox	☐	☐	____________________
Whooping Cough	☐	☐	____________________
RSV	☐	☐	____________________
Severe Flu	☐	☐	____________________
Strep Throat	☐	☐	____________________
Meningitis/ Encephalitis	☐	☐	____________________
Abscessed Ears	☐	☐	____________________
Tubes in Ears	☐	☐	____________________
Allergies	☐	☐	____________________
Asthma	☐	☐	____________________
Seizures	☐	☐	____________________
Heart/Blood Pressure Problems	☐	☐	____________________
Thyroid/Endocrine Problems	☐	☐	____________________
Diabetes	☐	☐	____________________
Gastrointestinal Problems	☐	☐	____________________
Nervous System Problems	☐	☐	____________________

Gynecological Problems	☐	☐	___________________
Sexual Problems	☐	☐	___________________
Head Injuries	☐	☐	___________________
Other Injuries	☐	☐	___________________
Hospitalizations	☐	☐	___________________
Hearing Problems	☐	☐	___________________
Vision Problems	☐	☐	___________________
Other	☐	☐	___________________

Do you currently take medication for a medical illness? ☐ No ☐ Yes
If yes, please describe: ____

____

Do you have known allergies to any medications? ______________________________

____

Do you wear glasses or contact lenses? If so, to see close up or far away?________________

____

Self Care:

Do you currently exercise? ☐ No ☐ Yes (describe routine): ________________

____

Describe your diet: ☐ Eat too much ☐ Eat too little ☐ Just right ☐ Picky ☐ Rituals surrounding food ☐ Generally Healthy ☐ Too much sugar/processed food ☐ Eat out frequently
Comments about diet:____

Describe your sleep hygiene: ☐ Sleep too much ☐ Sleep too little ☐ Just right ☐ Trouble falling asleep ☐ Go to bed too late ☐ Night waking ☐ Can't get back to sleep ☐ Wake too early ☐ Trouble waking up/getting out of bed ☐ Loud snoring ☐ Sleep apnea ☐ Teeth grinding

Time you usually fall asleep during the week: ___________ Time you wake up: ___________

Do you meditate or engage in mindfulness practice? ☐ No ☐ Yes (describe routine):

____

Family Medical/Psychiatric History:

Have any of your **biological relatives** had physical health problems?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: ____

____

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____

____

Have any of your **biological relatives** had mental health problems?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: ____

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Outside of biological relatives, are there **any other people with whom you have significant contact** who have medical or psychiatric problems that affect you?

☐ No ☐ Yes ☐ Don't know

If yes, please describe whom/illness/treatment: ____

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Academic Information:

Highest Level of Education (circle): GED high school some college trade school college degree

(indicate in what area/major) - associates:____________ bachelors: _____________ masters: ____________

Advanced masters/graduate degree: _____________ doctorate: ___________

List colleges and universities attended and years: Degree obtained? GPA (approx.)?

____ _______________ ______________

____ _______________ ______________

____ _______________ ______________

____ _______________ ______________

____ _______________ ______________

Previous schools (preschool, elementary, middle, high school) attended and grade levels:

Previous schools (preschool, elementary, middle, high school) attended and grade levels	Academic Struggles?		Behavioral Struggles?	
______________________________	☐ Yes	☐ No	☐ Yes	☐ No
______________________________	☐ Yes	☐ No	☐ Yes	☐ No
______________________________	☐ Yes	☐ No	☐ Yes	☐ No
______________________________	☐ Yes	☐ No	☐ Yes	☐ No
______________________________	☐ Yes	☐ No	☐ Yes	☐ No

Repeated Grade?: ☐ No ☐ Yes: reasons: ____

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____

Skipped Grade?: ☐ No ☐ Yes: reasons: ____

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<u>Behavior Consequences?</u>

In-school Suspensions: ☐ No ☐ Yes: grade level and reasons:__________________________

Out-school Suspensions: ☐ No ☐ Yes: grade level and reasons:__________________________

Expulsions? ☐ No ☐ Yes: grade level and reasons:__________________________

How did /would your teachers generally describe your behavior at school?__________________________

____

____

____

Learning Difficulties/Strengths? ☐ No ☐ Yes (describe):

Has testing ever been completed? ☐ No ☐ Yes: results? (Please provide copies if possible):______

____

____

Did you have an IEP/504 Plan/accommodations: ☐ No ☐ Yes: details:____________________

____

Did you have a DEP/gifted services: ☐ No ☐ Yes: details:____________________________

____

What did you like most/dislike most at school?____

____

____

Which of the following problems, if any, did you have in school?

☐ Did not do homework
☐ Failed to check work
☐ Incomplete homework
☐ Not remaining seated
☐ Inattention in class
☐ Distraction
☐ Forgot assignments
☐ Many careless errors
☐ Incomplete classroom work
☐ Disorganization
☐ Talked excessively
☐ Anxiety
☐ Below Average reading skills
☐ Below Average spelling
☐ Below Average math
☐ Below Average written language
☐ Below Average handwriting
☐ Excessive time to complete work

Further comments on homework, academic functions:________________________________

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____

Employment History:

List jobs and years worked at that job:	Full or Part Time?	Reason left?

Further comments on job functioning – how do your difficulties affect your ability to do your job?:____

Psychosocial Functioning:

Which of the following, if any, describe(s) your interactions with peers as a child?

☐ No friends ☐ Average number of friends ☐ Trouble keeping friends

☐ Few Friends ☐ Socially comfortable ☐ Trouble making new friends

☐ Controlling ☐ Aggressive ☐ Bullying

☐ Excessively shy ☐ Overall social ☐ Socially awkward

Extracurricular/Group Activities as a child/high school/college:____________________________

Further comments on peer functioning:____

Current social problems:

☐ No friends ☐ Average number of friends ☐ Trouble keeping friends

☐ Few Friends ☐ Socially comfortable ☐ Trouble making new friends

☐ Talk too loud ☐ Trouble listening in conversations ☐ Talk excessively

☐ Excessively shy ☐ Blurt out things without thinking ☐ Socially awkward

☐ Difficulties with dating ☐ Problems keeping romantic relationships

How would you describe your current social functioning? How do your problems affect your relationships?:____

____

____

____

Therapy History:

Has you ever received talk therapy? ☐ No ☐ Yes

If no, please go to medication questions.

If yes, please complete the following:

Have you received Cognitive Behavioral Therapy (CBT)? ☐ No ☐ Yes ☐ Don't know

If yes, did it include assigned "homework"? ☐ No ☐ Yes ☐ Don't know

Provider	Reason for treatment	Length of treatment	Outcome

Has your ever taken psychiatric medication? ☐ No ☐ Yes

If yes, please complete the following:

Medication	**Dosage**	**Dates of Use**	**Prescriber**	**Benefits**	**Side Effects**

Have you ever been hospitalized for mental health treatment? Please explain:

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Is there anything else you would like us to know about you before we meet?

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