

Name: _____

Date: _____

GENERAL HISTORY QUESTIONNAIRE

Reason(s) for testing:

Is this evaluation part of a lawsuit or criminal charge? Yes No

• If yes: Lawsuit LPS/Conservatorship Criminal

• Evaluation arranged by:

Dr. _____ Attorney Other side's attorney District Attorney Judge Other: _____

Was this evaluation recommended by a physician or other professional? Yes No

• If yes: Primary care: _____ Neurologist: _____ Pediatrician: _____

Psychiatrist: _____ Psychologist/Therapist: _____

Is this evaluation/ referral a result of injury, accident, or illness? Yes No

• If yes, date of injury, accident, illness (when symptoms started): _____

Do you experience any memory problems? Yes No If so, please check and/or circle to specify:

Difficulty recalling phone numbers, directions, people's names, what just happened

Difficulty recalling events that happened recently, news, assignments, appointments

Difficulty recalling your birthday, birthplace, childhood, historical events

Other: _____

Do you experience any speech/language problems? Yes No If so, please check and/or circle to specify:

Finding words

Organizing thoughts and putting them into sentences

Clearly understanding what others are saying

Other: _____

Do you experience any attention/organizational problems? Yes No If so, please check and/or circle to specify:

Had hard time paying attention even for short periods of time, very distractible, daydreaming, lost in own thoughts

Can concentrate for a while, but become distracted after a while, can't keep track of information for long periods of time

Hard time following lectures, following conversations

Hard time organizing thoughts, the tasks that need to be completed

Despite efforts, things are messy, lose things all the time, hard to find things needed to complete work

Hard to manage/concentrate

Please provide a brief summary of your main complaints. Describe how your problems began, the major problems you initially experienced and current problems you are experiencing.

Name: _____

Date: _____

BACKGROUND HISTORY

Location of birth: _____ Location for majority of childhood: _____

Mother is: Living Deceased Unknown

If living, her health is: Excellent Good/normal Fair Poor

If deceased, year of death _____, age _____, cause _____

Father is: Living Deceased Unknown

If living, his health is: Excellent Good/normal Fair Poor

If deceased, year of death _____, age _____, cause _____

Including your current marriage, please list the total number of marriages:

Year of Marriage #1: _____ to _____ Now: Married Divorced Widowed

Year of Marriage #2: _____ to _____ Now: Married Divorced Widowed

Year of Marriage #3: _____ to _____ Now: Married Divorced Widowed

Do you have any children? Yes No If yes: Males (ages: _____) Females (ages: _____)

Do any of your children live with you? Yes No If yes, which ones? _____

Do any of your children have health problems?? Yes No If yes, please specify: _____

Including all natural siblings, living or not living, please describe the number of siblings growing up.

_____ Brothers _____ Half-brothers _____ Step-brothers

_____ Sisters _____ Half-sisters _____ Step-sisters

Were you the: Only child Oldest Youngest Middle Other: _____

Did any of your siblings have serious health problems? Yes No

If yes, please explain: _____

Did any of your siblings have serious learning problems? Yes No

If yes, please explain: _____

DEVELOPMENTAL HISTORY

Prenatal Information

To the best of your knowledge, while pregnant with you, was your mother:

A smoker? Drug user? Alcohol user/abuser? Physically abused/victim of domestic violence?

Diagnosed with a psychiatric illness? (e.g. depression, anxiety, bipolar disorder, etc.) If so, please specify: _____

Please elaborate on any items above that were checked: _____

To the best of your knowledge, did your mother have to take any medication(s) during the pregnancy? Yes No

If yes, please specify: _____

To the best of your knowledge, while pregnant with you, did your mother experience any:

Injuries? Illnesses? Fainting spells? Bleeding? Anemia?

Hospitalizations? Surgeries? Abdominal impact? Other conditions: _____

Name: _____

Date: _____

Please elaborate on any items above that were checked: _____

Delivery and Early Childhood Information

To the best of your knowledge, the pregnancy was: Full term Premature If premature, by how many months? _____

To the best of your knowledge, the labor was: Normal Abnormal Was there: Use forceps? Fetal distress?

Was medication given during delivery? Yes No

To the best of your knowledge, the delivery was: Routine Caesarian Breech Other: _____

Apgar (if known): _____ Weight at birth: _____ lbs _____ oz Please explain: _____

Were there complications such as: Cyanosis? Jaundice? Limpness? Congenital defects? Hypoxia Other

If so, please elaborate: _____

Was there a need for the following: Oxygen? Transfusions? Tube feedings? Unusually long hospital stay?

If so, please elaborate: _____

Were you breastfed? Yes No If yes, until how old? _____

Were you bottlefed? Yes No If Yes, until how old? _____

Were there difficulties with feeding? Yes No Sucking? Yes No Swallowing? Yes No

If so, please elaborate: _____

During infancy, were you: (may check all that apply)

Slow to calm? Fussy, irritable, or colicky? Alert? Passive?

Fussy eater? Non-demanding? Quiet? Active?

During infancy, sleep patterns could be best described as: Regular Irregular

If irregular, please describe: _____

Please add additional information regarding infancy that was not inquired in the space below: _____

At what age you: Roll over both ways? _____ DK Crawl? _____ DK Sit alone? _____ DK

Walk? _____ DK Speak 1st word? _____ DK 1st sentence? _____ DK Drink independently? _____ DK

Feed self? _____ DK Take first steps? _____ DK Walk independently? _____ DK Dress by self? _____ DK

Use spoon independently? _____ DK Put on shirt independently? _____ DK Button independently? _____ DK

Developmental Milestones Guide: Normal Attainment Ages

Motor: Held head up: **1mo** Sat up: **7-10mos** Stood up: **1yr** Walked: **1.5yrs** Ran, climbed stairs: **2yrs**

Talk: Vocalized **6mos** Vocalized to Name: **7-11mos** 1 Word: **11-12mos** 2-Word Sent: **1-2yrs** Complete sentence: **2-3yrs**

Toilet: Day urination control: **2.5yrs** Night urination control + Bowel Control: **4 yrs**

At what age was the patient: daytime toilet trained? _____ DK nighttime toilet trained? _____ DK

Has the patient been diagnosed with enuresis? Yes No If yes, please elaborate: _____

Name: _____

Date: _____

Early Childhood Information

Please provide dates of illness for the following, or mark N/A:

	Date	N/A		Date	N/A		Date	N/A
Lung Problems			Mumps			Heart Trouble		
Meningitis			Measles			Excessive Vomiting		
Chicken Pox			Diabetes			Tuberculosis		
High Fevers			Allergies			Seizures		
Scarlet Fever			Polio			If so, how often? _____		
Whooping Cough			Ear Infection(s)					
			Did treatment require inner ear tubes? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Please provide additional information: _____

As a child, were there any physical injuries or surgical procedures? Yes No

If yes, please describe: _____

Aside from the aforementioned physical injuries/surgeries, have there been any other incidents requiring hospitalization? Yes No

If so, please provide: date: _____ incident information: _____
date: _____ incident information: _____

As a child, were there any incident(s) of: Head trauma? Loss of consciousness? Concussion? Exposure to toxins?
 Impact to head (sports, falls, accidents)? Suffocation/accidental drowning?

If so, please provide: Date: _____ Incident information: _____
Date: _____ Incident information: _____

As a child, were you:

Physically abused? Yes No Possibly Please explain: _____

Emotionally abused? Yes No Possibly Please explain: _____

Mentally abused? Yes No Possibly Please explain: _____

Sexually abused? Yes No Possibly Please explain: _____

Neglected? Yes No Possibly Please explain: _____

During childhood, were there major stresses/problems in the home? Yes No

If yes, please indicate: broken home death of parent serious illness substance use other: _____

Please provide more information: _____

SOCIAL HISTORY

As a child/adolescent, were you considered: "Different"? Introverted? Hostile/aggressive? Extroverted/outgoing
 In the "in" group/popular "Dancing to beat of your own drum"?

Did you have a normal social life? Yes No Did you have a normal number of friends? Yes No

Please provide additional information: _____

Name: _____

Date: _____

EDUCATIONAL HISTORY

How many years of formal education have you received? _____

Diploma = 12
AA=14

BA/BS=16
MA/MS=18

Ph.D/MD/Ed.D=20

Please check highest level of degree attained: HS Diploma/GED AA/AS BA/BS MA/MS Ph.D/MD/JD

Typical grades in college/high school: _____ Grade Point Average in college/high school: _____

Please list the most recent three schools attended:

dates: _____ to _____ School: _____ Graduated? Yes No Mo/Yr: _____ Degree: _____

dates: _____ to _____ School: _____ Graduated? Yes No Mo/Yr: _____ Degree: _____

dates: _____ to _____ School: _____ Graduated? Yes No Mo/Yr: _____ Degree: _____

Have you ever been held back/repeat a grade: Yes No If yes, what grade(s)? _____

Please specify reason(s) for being held back: _____

Have you ever been told you had any of the following:

A learning disorder? Yes No If Yes: Reading Spelling Writing Math Other

Attention Deficit Disorder? Yes No If Yes: ADD ADHD Age at diagnosis: _____

Who tested you/made the diagnosis? Teacher Counselor Psychologist Other _____

What were your best/easiest/favorite subject(s) in school? _____

What were your worst/hardest/least favorite subject(s) in school? _____

EMPLOYMENT HISTORY

Are you currently: Employed Employed, on leave Retired On disability

Unemployed Student Homemaker On SSI/SSD

What is your most current job title/description? _____

How long have you worked in this capacity? _____ When did you last work? _____

If unemployed, why did you leave? Laid Off Moved Quit Fired Retired Worker's compensation

Please list your current and prior jobs, most recent first:

Dates: _____ Employer: _____

Job duties/title: _____ Avg hrs/wk: _____ Why you left: _____

Dates: _____ Employer: _____

Job duties/title: _____ Avg hrs/wk: _____ Why you left: _____

Dates: _____ Employer: _____

Job duties/title: _____ Avg hrs/wk: _____ Why you left: _____

Dates: _____ Employer: _____

Job duties/title: _____ Avg hrs/wk: _____ Why you left: _____

Have you ever been in the military? Yes No If yes, complete below:

Branch? _____ MOS: _____ From: _____ To _____

Discharge type: Honorable General Medical/Mental Highest Rank _____ Lost Rank? Yes No

Where did you serve? _____

Name: _____

Date: _____

Do you have a service connected disability? Yes No If yes, please elaborate:

% _____ for _____

% _____ for _____

% _____ for _____

% _____ for _____

Add other information you feel it is important for us to know: _____

LEGAL HISTORY

Have you ever been arrested? Yes No If yes, please complete below. Please indicate frequency and/or date:

Assault _____ Robbery _____ Burglary _____ Disturbing the Peace _____

Drug Possession/Sales _____ Forgery _____ Homicide _____ Spousal Abuse _____

Auto Theft _____ Fraud _____ DUI _____ Sexual Offense _____

Details: _____

Excluding any current and/or ongoing lawsuit, have you ever been engaged in a lawsuit claim:

Personal Injury? Yes No Harassment? Yes No Unlawful Termination? Yes No

Please give details about when (what year), what the lawsuit was about, who was involved in the suit, and what the

outcome of each lawsuit was: _____

DRIVING HISTORY

Do you have a valid driver's license? Yes No Ever lost license or had it suspended? Yes No If yes, due to:

Speeding DUI Too many tickets Seizures No insurance Other: _____

Did you drive here today? Yes No Are you currently unable to drive? Yes No

How many motor vehicle (car, truck, motorcycle) accidents have you been involved in the last 10 years?

<circle> none 1-2 3-4 5+ How many were the patient's fault? <circle> none 1-2 3-4 5+

MEDICAL HISTORY

Current height is: _____ ft _____ in Current weight: _____ lbs Ideal weight: _____ lbs

During the past 3-6 months, weight has Increased _____ lbs Decreased _____ lbs Stayed the same

Weight change mainly due to: Illness Diet Change Less/more Exercise Don't Know

Sleeping pattern: Most nights I sleep well Sleeping problems began _____

Difficulty getting to sleep Difficulty staying asleep Awaken too early, cannot get back to sleep

Frequent bad dreams or repeating dreams about: _____

Do you have sleep apnea? Yes No Use CPAP Machine? Yes No Not anymore

In order to sleep, do you: Take pills? Drink alcohol? Take a bath? Meditate? None of these

Do you suffer from frequent and/or extreme headaches (i.e. so bad that a prescription was given)? Yes No

If yes, headaches are currently: Mild Moderate Severe

Name: _____

Date: _____

Headaches occur: Many times daily Once a day Once/several times per week Several times per month

When did these headaches begin? _____ What caused them? _____

Were there long periods without headaches? Yes No

Place letters to show Typical [T], Lowest [L], and Highest [H] headache levels

Rating									
1	2	3	4	5	6	7	8	9	10
No Problem	Mildly Painful		Moderately Painful			Very Painful			Unbearable

What seems to start or prolong the headache? Nothing Loud Noise Stress/worry Cold air

Bright/flashing lights Certain foods Certain Drinks Other: _____

What seems to reduce or stop the headache? Nothing Alcohol Rest/relaxation

Coffee/tea Medication: _____ Herbal medicine: _____

Has there been any change in sensation? Yes No If yes, please indicate areas of numbness/reduced sensation:

Left: Entire left side Or Only: Shoulder Face Hand Upper body Leg Foot/toes

Right: Entire right side Or Only: Shoulder Face Hand Upper body Leg Foot/toes

Has there been any change in taste/smell? No Yes, please indicate: Taste Smell Both taste and smell

Since when? Can't say Date: Month/Year: _____ Accident: _____ Illness: _____

Mold Chemicals: _____ Other substances: _____

Do you have a history of stroke or "CVA"? Yes No

If yes, please complete below:

Date: _____ Type (if you know): Hemorrhage Aneurysm Embolism Thrombosis Ischemia

AV Malformation What, if any, was your weak side? Left Right

Date: _____ Type (if you know): Hemorrhage Aneurysm Embolism Thrombosis Ischemia

AV Malformation What, if any, was your weak side? Left Right

Please provide additional information if possible: _____

Do you have a history of brain infection/brain related disease? Yes No

If yes, please complete below:

Date: _____ Type (if known): Meningitis HIV Lupus Herpes Encephalitis Brain cyst Other

Date: _____ Type (if known): Meningitis HIV Lupus Herpes Encephalitis Brain cyst Other

Please provide additional information if possible: _____

Is there a history of: [please circle to specify]	Patient		A Family Member? <circle>				
Chronic Fatigue Syndrome	Yes	No	Sister	Brother	Parent	Grandparent	Child
Fibromyalgia	Yes	No	Sister	Brother	Parent	Grandparent	Child
Back/Neck/Spine Problems	Yes	No	Sister	Brother	Parent	Grandparent	Child
Vision Problems: <input type="checkbox"/> corrective lenses <input type="checkbox"/> no corrective lenses	Yes	No	Sister	Brother	Parent	Grandparent	Child
Hearing Problems: <input type="checkbox"/> hearing aid <input type="checkbox"/> no hearing aid	Yes	No	Sister	brother	Parent	Grandparent	Child
Allergies [Pollen, dust, cats, foods, milk, drugs]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Bladder Disease [Chronic infection]	Yes	No	Sister	Brother	Parent	Grandparent	Child

Name: _____

Date: _____

History (continued):	Patient		Family History <circle>				
Cancer [Breast, Ovarian (women), Prostate (men)]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Diabetes [High blood sugar]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Eating Disorder [Anorexia Nervosa, Bulimia]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Epileptic Fits or Seizures	Yes	No	Sister	Brother	Parent	Grandparent	Child
Erectile Dysfunction [Impotence; Men] Sexual Arousal Disorder [Women]	Yes	No	Sister	Brother	Parent	Grandparent	Child
HIV Positive Blood Test/AIDS	Yes	No	Sister	Brother	Parent	Grandparent	Child
Kidney Disease [Kidney stones, kidney failure]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Liver Disease [Cirrhosis, Hepatitis, Jaundice]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Lyme Disease [Bitten by a deer tick]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Osteoporosis [Loss of bone density with age]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Thyroid Disease [Hypo=low; Hyper=high]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Heart Problems [Heart attack, Abnormal rhythm, Mitral valve, Pacemaker, Bypass, Angioplasty, Cholesterol]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Stomach/Intestinal [Ulcers, Gastritis, Acid reflux, Crohn's Disease, Colon cancer, Irritable bowel, Chronic diarrhea]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Blood Pressure [High, Low, Fainting Spells, Dizzy/Light-Headed]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Cognitive Disorder [Delirium, Dementia, Alzheimer's, Amnesic]	Yes	No	Sister	Brother	Parent	Grandparent	Child
Disorders with genetic predisposition [Parkinson's, Huntington's, etc]	Yes	No	Sister	Brother	Parent	Grandparent	Child

Please list all the drugs/medicines you are now taking, including prescription and non-prescription drugs (i.e. cold remedies, antacids, Aspirin, Tylenol, etc., herbal supplements, homeopathic remedies):

Medication: _____ Dose (if known): _____/day Since: _____ For: _____

Medication: _____ Dose (if known): _____/day Since: _____ For: _____

Medication: _____ Dose (if known): _____/day Since: _____ For: _____

Please list any unpleasant side effects for these medications (i.e. dry mouth, drowsiness, insomnia, etc.)

Medication: _____ Side effects: _____

Medication: _____ Side effects: _____

Medication: _____ Side effects: _____

Have you ever had surgical procedures? Yes No If yes, please complete below, starting with the most recent:

Date: _____ Type of surgery: _____ Hospital: _____

Date: _____ Type of surgery: _____ Hospital: _____

Date: _____ Type of surgery: _____ Hospital: _____

Please provide additional information regarding surgical procedures if needed: _____

Name: _____

Date: _____

Have you ever had a brain study? Yes No

If yes, please check all that apply:

- Electroencephalogram (EEG) Computed Tomography (CT) scan Position Emission Tomographic (PET) scan
- Magnetic Resonance Imaging (MRI/fMRI) scan Brain Electrical Activity Mapping (BEAM)
- Single Photon Emission Computed Tomography (SPECT) scan Other: _____

If known, please indicate what the abnormal study showed: _____

Have you ever had a head injury? Yes No

If yes, please complete the following:

By "head injury," we mean an injury in which: a) the patient either hit his/her head on something, b) something hit the patient in the head, or c) the patient experienced such a severe whiplash that the patient was dazed, confused, or unconscious.

Date: _____ Cause: Car accident Fall Fight Bullet/Shrapnel Surgery Other: _____

Lose consciousness? Yes No If yes, how long were you unconscious for? Please indicate below:

5-60sec	1-5min	5-10min	10-20min	20-30min	30-60min	1-2hr	2-8hr	8-24hr	1-2day	2-6days	7-14days	2-4 weeks	>4wks
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Please provide additional information about the head injury below: _____

Please provide additional information about medical history that was not inquired in the space below: _____

MENTAL HEALTH HISTORY

Please check the statement that best applies:

- I have never been evaluated or treated for a mental or emotional problem
- I have has been evaluated, but never treated, for a mental or emotional problem

Why? _____ When? _____ Where? _____

Who did the evaluation? _____ Results? _____

- I have been treated for a mental or emotional problem for the first time at the age of _____ for:

Depression PTSD Bipolar/Manic Trouble with the law

Anxiety Schizophrenia School problems Marital problems

Parent/sibling problems Work problems Other: _____

When? (estimate year) _____ Where? _____

Who provided treatment? _____ Outcome: No change Some improv. Signif. Improve.

Type of treatment: Individual (1-to-1) Couples Family Group

Was medication prescribed? Yes No If so, please list:

Dates: _____ Prescription: _____ For: _____ Effective? Yes No

Dates: _____ Prescription: _____ For: _____ Effective? Yes No

Frequency of appointments: 2x per week Weekly Every 2 weeks 3-4x per month Irregular appts.

Name: _____

Date: _____

Later treatment(s): <estimate the year, identify the main problem(s), and the treatment provider.>

Year: _____ Problems: _____ Provider: _____

Year: _____ Problems: _____ Provider: _____

Year: _____ Problems: _____ Provider: _____

Are you currently in treatment for a mental health problem? Yes No If yes, please complete below:

Name of treatment provider: _____ Total visits to date (approx): _____

Frequency of appointments: 2x per week Weekly Every 2 weeks 3-4x per month Irregular appts.

Type of treatment: Individual (1-to-1) Couples Family Group

Was medication prescribed? Yes No If so, please list: _____

Dates: _____ Prescription: _____ For: _____ Effective? Yes No

Dates: _____ Prescription: _____ For: _____ Effective? Yes No

Have you seriously thought about, planned, or attempted suicide? None Ideation Plan Attempt

Reasons: _____

Please list plans or attempts:

Year: _____ Method: _____ Plan Attempt

Year: _____ Method: _____ Plan Attempt

Year: _____ Method: _____ Plan Attempt

Do you currently find yourself thinking very angry thoughts, or feeling very angry toward a certain person? Yes No

If so, please check all that applies: Spouse Ex-husband/wife
 Neighbor Parent Coworker
 Boss Child Other: _____

Please elaborate: _____

Do you own and/or have access to firearms (pistol, rifle, shotgun)? Yes No If yes, please complete below:

Type: _____ Had for: _____ Used for: _____

Location: Home Work Car Other: _____ Locked? Yes No

SUBSTANCE USE HISTORY

Have you ever been a regular drinker of alcohol? Yes No If yes, please complete applicable section below:

Have you ever been a regular user of street drugs? Yes No If yes, please complete applicable section below:

Alcohol use history

If you drink now, how much do you usually drink? (please include drink of choice and quantity) _____

Frequency: Very rarely or never 1-2 times per month About once a week
 2-5 times per week About every day Wine with meals
 Several drinks per day Drink until drunk Feels as if alcohol is a problem

If you drank in the past, how much did you usually drink? _____

Name: _____

Date: _____

Has alcohol use ever caused a problem in the following areas? Marriage Work Family Work/school
 Medical Conditions (such as cirrhosis, peripheral neuropathy, seizures) DUI If so, please elaborate:
Please provide details (when, where, how, frequency, etc.): _____

Have you ever been in a treatment program for alcohol problems? Yes No
If yes, please provide details (when, where, duration of stay, etc.): _____

Substance use history

Please choose the description that currently fits best:

- I am not a regular user of any recreational drugs now, but at a younger age I experimented with drugs
 - I now use marijuana rarely, but not other drugs such as cocaine, heroin, speed, methamphetamines
 - I now use marijuana more than 4 times a month I use one or more drugs at least once a week
 - I am a regular to heavy drug user I feel I have a drug problem
 - I am addicted to one or more drugs [including cocaine, heroin, speed, methamphetamines]: please check all that apply below
 - Marijuana Cocaine/crack Heroin Opium Methamphetamine or speed Ecstasy
 - LSD Acid Prescription drugs: Vicodin Oxycontin Phenobarbital Demerol Dilaudid
- Other: _____

Solvents/chemicals: Glue Gasoline Paint thinner Nitrous Oxide Other: _____

Was your drug use ever a problem in the following areas: Relationship Work Military School Legal
If so, please provide details (when, where, how, frequency, etc.): _____

Have you ever been in a treatment program for drug problems? Yes No
If yes, please provide details (when, where, duration of stay, etc.): _____

Other Substance Use

Are you a cigarette/cigar smoker? No, never smoked No, I quit in _____ Yes, I smoke _____ per day
How long have you smoked for? _____ Have you had any health problems due to smoking? _____
Are you trying to cut down or quit? Yes No Eventually

