Cognitive Performance & Health

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Cognitive Performance & Health

ADULT INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist_____

Date of Birth_____ Age_____ Right or Left Handed_____ Gender: Male_____ Female_____

Address_____ Email _____

Home Phone_____ Cell Phone_____

MEDICAL HISTORY

Name of Primary Care Physician:_____

Physician's Address:_____ Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Current Medication being taken:

1)_____ Dosage/Freq_____ Start Date_____ Purpose_____

2)_____ Dosage/Freq_____ Start Date_____ Purpose_____

3)_____ Dosage/Freq_____ Start Date_____ Purpose_____

4)_____ Dosage/Freq_____ Start Date_____ Purpose_____

Prescribed by:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle One) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have allergies? (Circle One) YES NO

Do you have asthma? (Circle One) YES NO

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop?_____

If yes, please list:

Type of Drug	How much	How often
_____	_____	_____

_____ _____ _____

_____ _____ _____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle One) YES NO

If yes, please list:

Type of Alcohol How much How often

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind?_____

Describe any important medical history, chronic ailments, or other health problems you experience:_____

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties?

Please list:_____

_____

_____

Have you ever been hit in the head, blacked out, or had a concussion? (Circle One) YES NO

If yes, how old were you?_____ Were you hospitalized?_____

SCHOOL AND FAMILY HISTORY

Do you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO

If yes, please explain:_____

_____

What was the last year of school you completed?_____ If you did not complete high school, please explain:_____

_____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)_____ Year(s)_____

(2) School(s)_____ Year(s)_____

(3) School(s)_____ Year(s)_____

How would you describe your current support network? (friends, relatives, etc.):_____

_____

Please check all information which applies to your biological parents:

MOTHER _____living FATHER _____living

_____deceased _____deceased

_____married _____married

_____divorced _____divorced

_____remarried _____# of times _____remarried _____# of times

With whom do you live? Mother_____ Father_____ Stepmother_____ Guardian_____ Grandparent_____

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?_____

_____

Were you adopted? (Circle One) YES NO

If yes, what was your age at this time?_____

Have you ever been in foster care? (Circle One) YES NO

If yes, what was your age at this time?_____

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Where do your parents live? Mother_____

Father_____

Describe your relationship with your mother while growing up:_____

_____

Currently:_____

_____

Describe your relationship with your father while growing up:_____

_____

Currently:_____

_____

Describe any problems that have occurred in your family relating to: Alcohol/drug abuse:

_____

_____

_____

Sexual/physical/emotional abuse:_____

_____

_____

_____

MARITAL STATUS

Marital status: _____Single/never married _____Married _____Separated _____Divorced _____Widowed _____Living w/someone

If currently married, when were you married?_____ If living w/someone, how long?_____

Please list your children:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you believe you feel:

_____sad _____anxious _____depressed _____frightened _____guilty _____angry _____ashamed _____aggressive _____resentful

_____worthless _____tearful _____irritable _____confused _____extreme ups/downs _____jealous _____hopeless _____helpless

_____annoyed

Describe any other feelings you have had:_____

_____

What activities or hobbies do you participate in?_____

_____

Do you participate in regular exercise? (Circle One) YES NO

Describe:_____

_____

Describe your current working environment:_____

_____

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:_____

_____

Have you had any change in eating habits? (Circle One) YES NO

Describe:_____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problems? (Circle One) YES NO

If yes, please explain:_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List any current impediments or problems you are having in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, problems with supervisors, etc.):

_____

_____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior. Please explain:

_____

_____

Please circle any of the following concerns that you or your family may be experiencing:

Nervousness	Toileting	Suicidal Thoughts	Nightmares
Shyness	Depression	Finances	Behavioral Problems
Separation/Divorce	Sexual Problems	Unhappiness	Temper
Drug Use	Alcohol	Work	Death of a Loved One
Anger	Self-Control	Tiredness	Appetite/Eating
Sleep	Stress	Ambition	Parenting
Relaxation	Headaches	Decision Making	Stomach Trouble
Legal Matters	Memory	Concentration	Marital Problems
Energy	Insomnia	Health Problems	Loneliness
Feeling Inferior	Education/School	Marriage	Children
Fears	Thoughts	Other:_____	

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses:

_____

_____

_____

_____

_____

Please list your Therapy goals:

_____

_____

_____

_____

_____

THANK YOU!