Community Mental Health Services
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Please complete the following form to the best of your abilities. Your answers will provide us with information about your medical and psychosocial history. We are particularly concerned about characteristics or experiences that can affect thinking abilities and emotional functioning, so that we can take them into consideration in our assessment. Please answer the questions honestly and completely. Information will be kept confidential as indicated in the privacy notice. We will review history with you, and you will have a chance to discuss your answers in detail and clarify any questions. Thank you!

A. Identification

Name: _____Today's Date: _____

Date of Birth: _____Age: _____Gender: _____Race/Ethnicity: _____

Highest grade completed: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Ok to leave message: Yes or No (please circle one)

Mobile Phone: _____Ok to leave message: Yes or No (please circle one)

B. Developmental History

In which city/state were you born? _____

During your *mother's pregnancy* with you, did your mother have any of the following medical problems?
- ❑ Required bedrest or hospitalization for medical problems
- ❑ Used alcohol or other non-prescription drugs
- ❑ Used prescribed medication other than vitamins
- ❑ Smoked cigarettes
- ❑ Was exposed to lead, solvents, or other toxic substances
- ❑ Had high blood pressure due to pregnancy
- ❑ Suffered a serious physical injury
- ❑ Other _____
- ❑ No problems during mother's pregnancy
- ❑ I don't know

During *your birth*, were there any of the following problems or complications?
- ❑ Born prematurely
- ❑ Had the cord wrapped around your neck at birth
- ❑ Had forceps used during your delivery
- ❑ Lack of oxygen or other fetal distress
- ❑ Low "APGAR" scores (poor vital signs at birth)

❑Treated in an infant Intensive Care Unit after your birth
❑Other birth complications_____
❑No problems during my birth
❑I don't know

Did you experience any of the following delays in your *development* as a child?
❑Walking late (after 1 ½ year of age)
❑Talking late (after 2 years of age)
❑Bedwetting (after 5 years of age)
❑"Tics" (involuntary movements/sounds such as grunting)
❑Social delays
❑Other delays _____
❑Normal developmental milestones
❑I don't know

Do you have a childhood history of any of the following?
❑Abuse
❑Head Injury
❑Seizures
❑Speech Problems
❑Learning disability
❑ADD/ADHD
❑Speech Therapy/Physical Therapy/Occupational Therapy (please circle)

C. Educational History Please briefly list information about your *high school and/or college/trade schools*
School Name Graduation Year Grades/GPA Major Degree Any accommodations?

Best subject(s): _____ Worst subject(s):_____Failed or repeated any grades? ❑No ❑Yes

SAT scores? _____ Any other known standardized test scores? _____

D. Occupational History

Currently Employed: ❑No ❑Yes. Briefly describe your *current and past employment* history:
Dates of employment Place of employment Job Title Job Duties Any job problems?

Have you done any kind of work where you were exposed to toxic chemicals? ❑ No ❑ Yes.
If yes, please explain dates, kinds of chemicals, kind of work and effects: _____

Military Service? ❑No ❑Yes Service Branch:_____Rank at discharge:_____ Year of discharge: _____
Combat experience?❑No ❑Yes Describe: _____

E. Medical History

Please list your current medical diagnoses: _____
Please list any surgeries and dates: _____
Please list your primary care physician name and phone number and the name and phone number of any specialists you see on a regular basis:

Have you had any of the following *neurological problems*?
❑ Head injury with loss of consciousness or confusion
❑ Seizures, epilepsy, or "fits"
❑ Stroke, brain hemorrhage, "TIA's" or other vascular problem
❑ High fever, meningitis, encephalitis, or other brain infection
❑ Fainting or dizzy spells?
❑ Brain tumor
❑ Loss of oxygen, choking, drowning, or suffocation
❑ Drug or alcohol overdose
❑ Severe or persistent headache, or migraine
❑ Parkinson's disease or other movement disorder
❑ Alzheimer's disease or other dementia
❑ Multiple sclerosis or other demyelinating disease
❑ Other neurologic disease _____
Have you had any of the following general *medical problems*?
❑ Allergies or asthma (please specify: _____
❑ Heart attack or heart failure or any other heart disease (please circle)
❑ High blood pressure
❑ High cholesterol
❑ High blood sugar or diabetes
❑ Liver disease, hepatitis, cirrhosis, or jaundice
❑ Kidney disease or dialysis
❑ Thyroid disease or other endocrine (gland) disorder
❑ Vitamin deficiency
❑ Cancer
❑ Other medical problems _____

Have you ever had any of the following problems? If so, please specify when they started.
❑ Balance problems or falls. Specify: _____
❑ Tremors, dexterity problems or numbness in hands or legs. Specify: _____
❑ Vision problems (e.g. blurred, double, floaters, sensitivity). Specify: _____
❑ Hearing problems (e.g. hypersensitivity, ringing, interference). Specify: _____
❑ Taste changes (e.g. unusual or unexpected tastes). Specify: _____
❑ Smell problems (e.g. difficulty identifying odors, unusual/unexpected smells). Specify: _____
❑ Temperature regulation problems (e.g. feeling hot or cold all the time). Specify: _____
❑ Changes in sexual interest or activity. Specify: _____
❑ Incontinence with bladder or bowels. Specify: _____
❑ Depression. Specify: _____
❑ Anxiety. Specify: _____
❑ Hallucinations (seeing/hearing/feeling things that others don't). Specify: _____
❑ Delusions (strong beliefs that most others don't share). Specify: _____
❑ Other emotional difficulties. Specify: _____

❑Car accidents. Specify: _____

List *all* medications, drugs, or other substances you are currently take or have taken in the last year—prescribed, over-the-counter vitamins, herbs, and others. If you have a list, you can provide a copy of the list.

Medication/drug Dose How often? Taken since Reason to take it? Is it effective?

List any other relevant medications taken the past: _____

Have you had any of these diagnostic tests?
MRI ❑ Date_____ Results_____
CT ❑ Date_____ Results_____
EEG ❑ Date_____ Results_____
Labs ❑ Date_____Results_____
Sleep Study ❑ Date_____Results_____

Have you ever received neuropsychological, psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑No ❑Yes. If yes, please indicate:
When? From whom? For what? With what results?

F. Health habits

Do you drink alcoholic beverages? ❑No ❑Yes
Current level of drinks per week: _____Types of drinks consumed: _____
Do near relatives ever worry or complain about your drinking? ❑No ❑Yes
Have you ever neglected obligations, family, or work because you were drinking? ❑No ❑Yes
Have you ever been arrested for drunken driving or driving while intoxicated? ❑No ❑Yes
Have you ever used non-prescription drugs? ❑No ❑Yes. If Yes, Specify which ones:
❑Barbiturates or "downers" (e.g. Seconal, Quaaludes, etc.) ❑Opiates (e.g. heroin, methadone, Demerol, "smack") ❑Amphetamines or "uppers" (e.g. Dexedrine, meth) or ❑Cocaine or "crack" ❑Marijuana or hashish
❑Hallucinogens (e.g. LSD or "acid", PCP or "angel dust", etc.)
❑Other _____

Do you consume coffee, soda, tea, or other sources of caffeine regularly? ❑No ❑Yes. # cups/cans per day_____
Do you consume tobacco? ❑No ❑Yes. # cigarettes/tobacco per day_____ If no, did you quit in the past? ❑No ❑Yes.
Are you satisfied with your sleep? ❑No ❑Yes. # hours of sleep/night _____# daytime naps _____
Do you exercise regularly? ❑No ❑Yes. If yes, how often? _____What type of exercise? _____

Do you have any legal history (e.g. law suits, arrests)? ❑No ❑Yes. If yes, please explain:

G. Family history

Mother: Alive? ❑No ❑Yes Age (or age at death):_____ Health problems?:_____ Job: _____
Father: Alive? ❑No ❑Yes Age (or age at death):_____Health problems? _____Job: _____

Brother(s): #: ___ Age(s): _____Health problems? _____

Sister(s): #: ___ Age(s): _____Health problems? _____

Your birth order: _____of _____

Are you currently in a relationship? ❑No ❑Yes. How long?_____
Are you married? ❑No ❑Yes. How long?: _____ Prior divorces? ❑No ❑Yes. # of times:_____ When?_____
Would you describe your current marriage/relationship as ❑Supportive ❑Neutral ❑Stressful ❑Destructive ❑None

Do you have children? ❑No ❑Yes. Names & ages:_____
Do your children have any behavioral or medical problems? ❑No ❑Yes.
Type:_____

Does anyone in your *family* have a history of any of the following disorders? (check which ones) Person affected

❑Seizures, epilepsy, or "fits"
❑Stroke, brain hemorrhage, "TIA's" or other vascular problem
❑Heart attack or heart failure or heart disease
❑Parkinson's disease or other movement disorder
❑Alzheimer's disease or other dementia
❑Genetic disorders
❑Liver disease, hepatitis, cirrhosis, or jaundice
❑Kidney disease or dialysis
❑Diabetes, thyroid disease or other endocrine (gland) disorder
❑Cancer. Specify type: _____
❑ADHD Learning Disability or Developmental Delays
❑Emotional problems (e.g. depression, anxiety, schizophrenia, bipolar, OCD). Please circle.
❑Problems with drugs or alcohol. Specify which: _____
❑Other serious medical or emotional problem? Specify: _____

Did you complete this form ❑Independently or were you ❑Helped by someone? Who? _____