HEALTH HISTORY QUESTIONNAIRE

Name _____ DOB:_____ Age: _____ Date_____
Referred By: _____ Handedness: Right /Left/ Ambidextrous Gender: Male / Female
Parent's names (if completing this form for your child): _____

(For child evaluations, please fill out questionnaire by substituting "your child's" for "you")

Please describe what your primary concern(s) are:

_____
_____
_____
_____
_____

What are the top five (5) symptoms or problems that **you** would like to see improved? (**List in order from Most to Least Important)**

1_____
2_____
3_____
4_____
5_____

Current Life Stressors (include anything that is currently stressful for you, examples include relationships, job, school, moving, finances, children): _____
_____
_____

Current Psychiatric Symptoms:

Do you have any of the following symptoms?	No Symptom never	Few or sometimes	Moderate or regularly	Much or often	Always or extreme
Depressed or sad mood	[ ]	[ ]	[ ]	[ ]	[ ]
Recurrent thoughts of death or suicide	[ ]	[ ]	[ ]	[ ]	[ ]
Sleep changes or sleepy during the day	[ ]	[ ]	[ ]	[ ]	[ ]
Appetite changes, increased or decreased	[ ]	[ ]	[ ]	[ ]	[ ]
Low energy or feelings of tiredness	[ ]	[ ]	[ ]	[ ]	[ ]
Feelings of worthlessness or hopelessness	[ ]	[ ]	[ ]	[ ]	[ ]
Feeling detached or distant from others	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased interest in important activities	[ ]	[ ]	[ ]	[ ]	[ ]
Irritable mood or mood swings	[ ]	[ ]	[ ]	[ ]	[ ]
Anger outbursts	[ ]	[ ]	[ ]	[ ]	[ ]
Poor motivation for required tasks	[ ]	[ ]	[ ]	[ ]	[ ]
Social isolation or withdrawal	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety	[ ]	[ ]	[ ]	[ ]	[ ]
Frequent worry	[ ]	[ ]	[ ]	[ ]	[ ]
Panic attacks	[ ]	[ ]	[ ]	[ ]	[ ]
Obsessive and/or compulsive behaviors	[ ]	[ ]	[ ]	[ ]	[ ]
Feelings of a situation "not being real"	[ ]	[ ]	[ ]	[ ]	[ ]
Phobias (heights, closed spaces, etc)	[ ]	[ ]	[ ]	[ ]	[ ]
A sense of reliving a past upsetting event	[ ]	[ ]	[ ]	[ ]	[ ]
Recurrent episodes of binge eating or food restricting	[ ]	[ ]	[ ]	[ ]	[ ]
Paranoid thoughts	[ ]	[ ]	[ ]	[ ]	[ ]
Aggressive or violent behavior	[ ]	[ ]	[ ]	[ ]	[ ]

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What do you feel are your greatest talents and strengths? _____
_____
_____

Past Psychiatric History: Please check if you have experienced or have been diagnosed with any of the following?

___ Attention Deficit Hyperactivity Disorder (ADHD)
___ Anxiety
___ Panic attacks
___ Depression
___ Bipolar Disorder
___ Mania
___ Obsessive Compulsive Discorder (OCD)
___ Phobias
___ Tics/ Tourette's Syndrome
___ Pervasive Developmental Delay
___ Autism
___ Asperger's Disorder
___ Schizophrenia
___ Loosing touch with reality
___ Antisocial behavior
___ Learning Difficulties
___ Mental retardation
___ Post Traumatic Stress Disorder (PTSD)
___ Physical Abuse
___ Sexual Abuse
___ Trauma

Inpatient psychiatric hospitalizations (location, dates of hospitalization, reason): _____
_____
_____

Prior Therapies (Individual, Couples, Group, Coaching, etc): _____
_____
_____
_____
_____
_____

Please list ALL prior psychiatric medications:

	Medication	Dose	Reason for Discontinuation
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

DIRECTIONS FOR DEVELOPMENTAL HISTORY SECTION

- For **child** assessments, please fill out this developmental section on behalf of your child.
- For **adult** assessments, please fill out what you recall from your own development.

Developmental History:

Are you adopted? Yes or No Length of pregnancy: _____ APGAR Scores at birth: _____

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Any complications of pregnancy or delivery (bleeding, excess vomiting, medication, infections, smoking, alcohol/drug use etc.)?

_____

_____

Languages spoken at home other than English: _____

Please circle any of the following that are occurring or did occur in infancy or childhood?

Delayed Developmental Milestones?	Behaviors	Early Intervention Services: (When?)
Crawling Walking Talking Motor skills Toilet training Separating Clumsy or uncoordinated	Colic Failure to thrive Bangs head Rocks back and forth Temper tantrums Repetitive behaviors/fixations Difficulty sitting in a chair	Speech and Language _____ Occupational Therapy (OT) _____ Physical Therapy (PT) _____ Title One Reading _____ Tutoring _____ Other _____ Forced to change writing hand from left to right?
Social:	Sensitivities (Give Examples)	Fine Motor
Inconsistent eye-contact Few or no friends Trouble reading body language Trouble reading facial expressions Uncomfortable with physical affection Limited facial expressions Difficulty understanding jokes	Texture _____ Sound _____ Light _____ Touch _____ Taste _____ Smell _____	Work tends to be messy Prefers to print rather than cursive writing Trouble staying within lines Takes a long time to complete tasks Problems with grammar or punctuation Reduced hand eye coordination Trouble getting thoughts from my brain to the paper
Learning Difficulty learning to read. Reverses letters when I read (such as b/d, p/q) Words tend to move around the page when reading Difficulty understanding the main idea Trouble copying off the board or from a book Trouble finding the right word to say in conversations Trouble getting to the point in conversations.		Poor spelling Trouble filtering out background noises Pronouncing words or names poor sense of direction Slow, deliberate speech Difficulty doing two things at once Trouble with automatically knowing: up/down, over /under, left/right

Educational History:

Level of education: _____ Repeated any grade? Yes or No Skipped any grade? Yes or No

Current Special Education Services: (IEP/504/accommodations/tutoring/counseling/social skills): _____

_____

_____

Areas of difficulty:_____

_____

Previous Supports (IEP/504/accommodations/tutoring/counseling/social skills): _____

_____

Test Taking Skills (anxiety/finish all items/multiple choice verses essay): _____

_____

Education Specifics:

Kindergarten (Any noted strengths or weaknesses): _____

_____

Elementary (grades/teacher comments): _____

_____

Middle (grades/teacher comments): _____

_____

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High School (grades/teacher comments):_____
_____
_____

College (where/major/years): _____
_____
_____

Prior Neuropsychological Testing or Assessments Completed (core evaluations/testing/neuropsychological/speech/ occupational):
_____
_____
_____
_____
_____
_____

State Mandated Tests(year/subject/scores)_____

SAT Exams	Date:	Date:	
Verbal Score Math Score Writing Score			Did you finish all items? Yes or No Did you apply for accommodations? Yes or No When do you expect to take the exam again? _____

Employment History: (If filling this form out for a child with no employment history please skip to health history section)

Current employer/position: _____
_____

How satisfied are you with your current employment? _____
Any work-related problems? _____
_____
_____

Employment History (summarize jobs you've had):_____
_____
_____
_____

Health History

Primary M.D: (Contact info): _____
Please list all Current Medical Conditions:_____
_____
_____
_____

Previous illnesses in infancy/childhood: _____
_____
_____

Any history of tic disorders/head trauma/seizures/tic disorders/loss of consciousness/migraines/neurological problems: _____
_____

Prior hospitalizations (place, cause, date, outcome): _____
_____
_____

Prior abnormal lab tests, X-rays, EEG, EKG etc: _____
_____
_____

Heart problems and/or family history of heart problems : _____
_____

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Thyroid problems and/or family history of thyroid problems : _____
_____
Glaucoma or problems with vision:_____
Hearing problems:_____
Food allergies:_____
Medication allergies (describe):_____
_____
Any recent use of antidepressants called MAO Inhibitors? Parnate? Nardil?_____

Please check all that apply to your <u>sleep patterns:</u>

_____trouble falling asleep _____trouble staying asleep _____do you wake up during the night?
_____do your legs jump often or do you kick your blankets off at night?
_____do you snore? If yes, do you have periods that you stop breathing (ask your bed partner)? Yes or No

How much caffeine do you drink a day (coffee, tea, soda, Red Bull type drinks? _____
Please quantify how often you: Smoke cigarettes? _____ Chew Tobacco? _____ Smoke marijuana? _____
How much alcohol do you drink?_____
Do you take any other non-prescription drugs? _____
Do you exercise regularly? Yes or No

Please list ALL Current prescription medications you are taking (medical, psychiatric, over-the counter):

<u>Medication</u>	<u>Dose</u>	<u>Describe reason for taking the medication</u>
1.		
2.		
3.		
4.		
5.		
6.		

Please list ALL nutritional supplements you take currently:

<u>Supplement</u>	<u>Dose</u>	<u>Describe reason for taking the supplement</u>
1.		
2.		
3.		
4.		
5.		
6.		

Social History

Adults, are you (circle one): married, single, separated, divorced, widowed Do you have children? Yes or No
If yes, what are their names and ages? _____
_____
Family structure; who lives in your current household(s):_____
_____

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Are your parents currently married, single, divorced, or widowed? _____

Please list any significant events and year each occurred (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.) _____

Legal history (speeding tickets/accidents/license suspensions/ law suits): _____

Do you file tax returns regularly and on time? _____

Risk taking activities:_____

Family Medical History: Please list any medical problems that run in your family including seizures, tic disorders, heart problems, cancer, etc. Please describe who (maternal or paternal grandparents, mother, father, siblings, aunts, uncles, children, cousins, etc.)

Family Psychiatric History: Please list any psychiatric problems or learning problems that run in your family including ADHD, dyslexia, depression, anxiety, eating disorders, manic depression, substance abuse, etc. Please describe who (maternal or paternal grandparents, mother, father, siblings, aunts, uncles, children, cousins, etc.) _____

DIET ANALYSIS

Please check the questions to which you would answer 'yes' or fill in the 'number of times' you eat the particular food.

1. ___ Were you breast feed?
2. ___ Was a significant percentage of your diet as a child high in fatty foods and sugar? _____
3. ___ Do you go out of your way to avoid foods containing preservatives or additives? _____
4. ___ Do you avoid foods which contain sugar? _____
5. ___ How many teaspoons of sugar do you add to food/drinks each day? _____
6. ___ Do you use salt in your cooking? _____
7. ___ Do you add salt to your food? _____

8. ___ How many coffees do you drink each day? _____
9. ___ How many cups of tea do you drink each day? _____
10. ___ How many times a week do you have meals containing fried food? _____
11. ___ How many packets of 'instant' or fast foods do you eat each week? _____
12. ___ How many times a week does you eat chocolate or confectionary sugar? _____
13. ___ What percentage of your diet is **raw** fruit and **raw** vegetables? _____
14. ___ Do you normally eat white rice or flour? _____
15. ___ How many cans of food do you eat per week? _____
16. ___ How many slices of bread or rolls do you eat each week? _____
17. ___ How many pints of milk do you drink in a week? _____
18. ___ How many times a week do you eat red meat? *(beef, pork, lamb or game)* _____
19. ___ How many times a week do you eat white meat? *(poultry, fish)* _____
20. ___ What is your usual alcoholic drink? _____
21. ___ How many glasses do you drink a week? _____
22. ___ How many times a week do you eat live yogurt? _____
23. ___ Do you use a water filter or drink bottled water instead of tap water? _____
24. ___ Do you frequently eat under stressful conditions or on the move? _____
25. ___ How would you describe your appetite? poor / average / good

Sample 24 Hour Diet

Write down all the foods and drinks consumed over the next day. Please add as much information as possible including quantities eaten brand names, and whether the food is fresh or packaged, refined or natural.

Day 1

Breakfast

Lunch

Dinner

Snacks/Drinks