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ADULT PATIENT INFORMATION FORM

Welcome to my office! So that we can spend sufficient time during our first meeting discussing what is most important to you, please take the time to complete this form as accurately and completely as you can.

Name _____ Social Security Number _____

Address _____

Telephone Number (home)_____ (work)_____ (cell)_____

Date of birth _____ Age _____

Spouse/Contact Person _____ Phone Number _____

Who referred you to my office? _____

CURRENT CONCERN

What problems or concerns bring you to my office? _____

_____

_____

Major symptom(s) _____

_____

_____

When did you first notice these problems? _____

_____

Are these problems related to either a motor vehicle accident or a work related injury? If yes, please ***circle*** and indicate the date of the accident.

Motor Vehicle Accident Work Related Injury Date of injury: _____

Are these problems: ☐Getting Better ☐Staying the Same ☐Getting Worse

Are you currently on disability? ☐Yes ☐No

If yes, why and how long? _____

Are you currently involved in any type of legal proceedings? ☐Yes ☐No

If yes, please describe. _____

_____

SYMPTOM CHECKLIST
Please indicate whether you have ever experienced any of the symptoms below, when, and briefly describe:

Symptom	Circle Yes or No		When it began	Please briefly describe Problem(s) and Treatments, if any
Loss of Consciousness	No	Yes		
Changes in ability to detect odors	No	Yes		
Seizures	No	Yes		
Dizziness	No	Yes		
Allergies	No	Yes		
Asthma	No	Yes		
High Fever	No	Yes		
Bowel or Bladder Problems	No	Yes		
Changes in ability to walk	No	Yes		
Blurred/Double vision	No	Yes		
Ringing in Ears	No	Yes		
Muscle Jerks or Twitches	No	Yes		
Chronic Pain	No	Yes		
Mental Confusion	No	Yes		
Speech Difficulties	No	Yes		
Memory Difficulties	No	Yes		
Weight Changes	No	Yes		
Sleep Difficulties	No	Yes		
Decreased Energy	No	Yes		
Decreased Motivation	No	Yes		
Decreased Happiness	No	Yes		
Social Isolation	No	Yes		
Persistently Depressed Mood	No	Yes		
Frequent Headaches	No	Yes		
Feeling Shaky	No	Yes		
Frequent Anxiety	No	Yes		
Excessive Worry	No	Yes		
Nightmares	No	Yes		
Angry Outbursts	No	Yes		
Feelings of Paranoia	No	Yes		
Unusual/Frightening Thoughts	No	Yes		

MEDICAL HISTORY

Primary physician's name _____ Date of last medical examination _____

Serious illness; neurological disorders _____

Surgeries; other medical procedures _____

Current medications _____

Please indicate if you have ever used any of the following. If yes, please ☒ and fill in the requested information.

Street Drugs? ☐No ☐Yes ; How often?_____ Stopped using? (if yes, when) _____

Alcohol? ☐No ☐Yes ; How often?_____ Stopped using? (if yes, when) _____

Cigarettes? ☐No ☐Yes ; How often?_____ Stopped using? (if yes, when) _____

Have you ever been told by a friend or family member that you have a problem with using alcohol or drugs?

O No O Yes ; Describe:_____

Are there any medical problems that run in your family? ☐No ☐Yes

If yes, describe: _____

_____

Is there anyone in your family that suffers from:

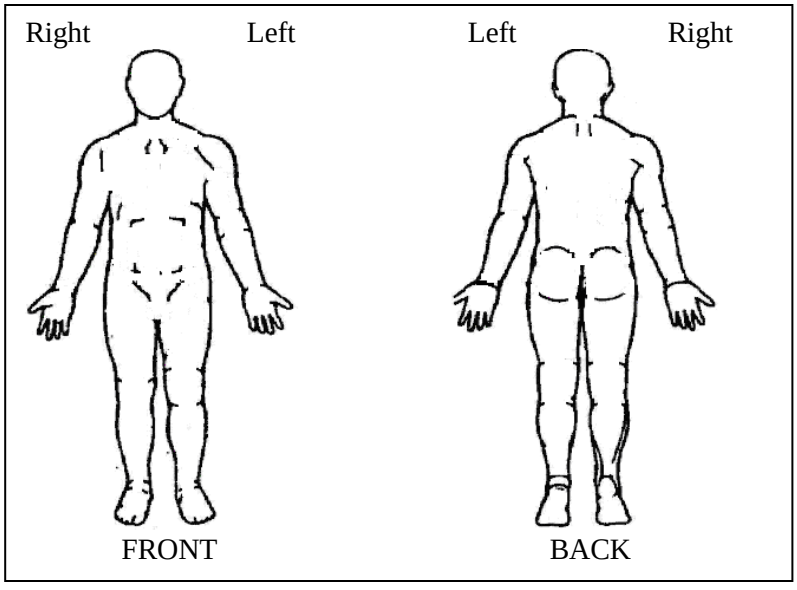
☐Alzheimer's Disease ☐Stroke ☐Heart Disease

☐Other neurological illness: _____

☐Other serious illness: _____

If physical pain is a presenting concern:

1. Please shade the diagram below to indicate the area(s) of your discomfort:



2. Please mark an "X" on the diagram below to rate the usual level of your discomfort:

0	1	2	3	4	5	6	7	8	9	10
None	Mild				Average					Severe

Have you ever received psychological treatment/therapy? ☐No ☐Yes

Have you ever received medication for psychological problems? ☐No ☐Yes

If yes, please describe the nature of the psychological problem(s) and treatment history _____

_____

_____

_____

Does anyone in your family have a history of mental disturbance? ☐No ☐Yes

If yes, please describe _____

_____

_____

Have you had any previous psychological or neuropsychological testing? ☐No ☐Yes

If yes, when and by whom _____

Please describe the results _____

_____

SOCIAL HISTORY

Are you currently:

☐Single (_____ years) ☐Married (_____ years) ☐Divorced (_____ years)

☐Separated (_____ years) ☐Widowed (_____ years)

Have you been married previously? ☐No ☐Yes

If yes, please complete the following:

Number of previous marriages: _____

Number of years married to each spouse: _____

Number of children resulting from each marriage _____

Spouse:

Name	*Age*	*Residence*	*Health Problem(s) (if any)*

Children:

Name	*Age*	*Residence*	*Health Problem(s) (if any)*

If there are any other members of your family with significant health problems, please indicate their name, age, residence, and a brief description of the problem(s): _____

_____

_____

_____

Where were you born and raised? _____

EDUCATION

Last grade completed _____

Usual grade in school (circle one) A B C D F

Were you ever held back or required to repeat a grade? If so, state which grades and explain the circumstances

_____

_____

Did you receive any special education in school? ☐No ☐Yes

If yes, please describe _____

_____

Were you ever told you have a learning disability? ☐No ☐Yes

If yes, please explain _____

_____

OCCUPATIONAL HISTORY

List your current or last occupation _____

Describe the responsibilities of your job _____

_____

Are you retired? ☐No ☐Yes ;If yes, how long: _____

LEGAL HISTORY

Describe any history of legal difficulties: _____

_____

_____

_____

MILITARY HISTORY

Have you ever served in the military? ☐No ☐Yes

If yes, please explain _____

_____

_____

_____

This form was completed by:

_____ _____

Signature Print Name

_____ _____

Date Completed Relationship to Patient