Jillian DePaul, Ph.D.
2 Summer St.
Suite 2
Natick, MA 01760

ADULT HISTORY FORM

Date: _____
Name: _____ Age: _____ Date of Birth: _____
Address: _____
_____
Best phone number: _____
Occupation: _____ Marital Status: _____
Handedness: Right Left Mixed
Ethnicity or Race _____ Primary Language _____
Who referred you to my office?_____

What is your major concern that led you to seek help? _____
_____
_____
_____
_____

What other concerns do you have? _____
_____
_____
_____

Have you been diagnosed with any psychiatric conditions? If so, what are they? _____
_____
_____

Do you currently have a psychiatrist? Yes _____ No _____ Name _____
Do you currently have a therapist? Yes _____ No _____ Name _____

MEDICAL HISTORY

Primary Care Provider _____
For what conditions are you currently being treated, including those being treated by medical providers other than your primary care provider?
_____
_____
_____

Please list all current medications, dosages and duration of use:

Medication Dosage Approximate Duration of Use

_____
_____
_____
_____

Please list any previous psychiatric medications that you have taken and discontinued: _____
_____
_____

Please list all surgeries with approximate dates or ages: _____
_____
_____

Please list all hospitalizations with approximate dates or ages: _____
_____
_____

What other medical or physical problems have you had? Please mark all that apply.

___ Head injury/concussion ___ Poor circulation ___ Fibromyalgia

___ Respiratory problems ___ Headaches/migraine ___ Gastrointestinal problems

___ Chronic pain ___ Memory changes ___ Hearing/speech disorders

___ Diabetes/Hypoglycemia ___ Seizure(s) ___ Loss of consciousness

___ Thyroid problems ___ Heart problems ___ Arthritis/Joint pain

___ Hypertension ___ Neurological problems (numbness, tingling, weakness)

Have you ever seen a neurologist for any reason? _____
_____
_____

Do you have any allergies? _____
_____
_____

On average, how many hours of sleep do you get per night? _____

Please check any of the following sleep problems you have now or have experienced in the past:

___ Difficulty falling asleep

___ Difficulty waking in the morning

___ Frequent waking

___ Not rested after sleep

___ Nightmares

___ Sleep apnea

___ Sleeping too much

___ Teeth grinding

Do you exercise regularly? No ___ Yes ___

Do you drink alcohol? No ___ Yes ___
If yes, how many occasions of drinking alcohol per week? _____
How many drinks, on average, per occasion of drinking? _____
Are you or have you have been concerned about your drinking? _____
_____
Has a friend of family member ever told you that they are concerned about your drinking? _____
_____

Do you use illegal drugs? No ___ Yes ___ If so, please describe. _____
_____

DEVELOPMENTAL HISTORY

Were there any problems/complications during pregnancy or delivery? No ___ Yes ___ Unsure ___
If so, describe: _____
Were you adopted? No ___ Yes ___ If yes, at what age? _____

Were there any delays in your development of language? No ___ Yes ___ Unsure ___
If so, describe: _____

Were there any delays in your development of motor skills, such as sitting up independently, crawling and walking? No ___ Yes ___ Unsure ___
If so, describe: _____

As a child, did you experience physical, sexual or emotional abuse? No ___ Yes ___ Unsure ___

As a child, did you experience any significant stressors, such as serious illness, frequent moving, family drug or alcohol abuse? No ___ Yes ___ Unsure ___

Please check any of the following that were a problem for you during your school years:

____ Reading difficulties, including decoding or reading comprehension

____ Math difficulties

____ Writing difficulties, including poor spelling and handwriting

____ Poor visual-spatial skills (drawing, copying figures)

____ Poor grades

____ Behavior problems

____ Peer problems

Highest educational level completed? _____

Current employment? _____

Previous employment history? _____
_____
_____

BEHAVIORAL ISSUES

Please indicated if you have or have had difficulty with any of the following areas:

___ Inattention/distractibility	___ Hyperactivity/impulsivity	___ Depression
___ Poor anger management	___ Compulsive behavior	___ Agitation
___ Panic attacks	___ Phobias	___ Muscle/Verbal Tics
___ Obsessive thinking	___ Inability to read social cues	___ Poor self-esteem

Have you ever been violent or destructive? Have you ever hurt an animal or person intentionally, or threatened to harm or kill someone? _____
_____

Have you ever been arrested or had legal problems? _____
_____

Have you ever considered suicide or attempted suicide? If yes, please describe? _____
_____
_____

Please list family psychiatric history. Are you aware of any of your biological relatives having been diagnosed with a psychiatric or mental health disorder (such as depression, anxiety, Bipolar Disorder, PTSD, schizophrenia), an attention disorder (such as ADHD), a learning disorder (such as dyslexia, dysgraphia or dyscalculia), or a developmental disorder (such as Autism Spectrum Disorder), a personality disorder (Borderline Personality Disorder, Narcissistic Personality Disorder)? If you strongly suspect someone in your family suffered from a disorder that was diagnosed, please include that here:

_____
_____
_____
_____

FAMILY/SOCIAL ISSUES

Who is living in your home? _____
_____
_____

Have you recently had any disruptions in your life, including family crisis, conflicts, grief or other loss, financial problems, job difficulties, etc? If yes, please explain: _____
_____
_____

Have you ever experienced trauma or abuse (e.g., physical, sexual, emotional/verbal)? _____
_____
_____

Do you have a social support network? _____
_____

What are your strengths? _____
_____

GOALS

If you are seeking evaluation, what questions do you have that you would like to have answered through the evaluation process? What are your goals for the evaluation? _____

_____

_____

_____

_____

If you are seeking therapy, what are your goals for therapy? _____

_____

_____

_____

_____