ADULT FORM

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.

IMPORTANT! **PLEASE BRING ANY RECORDS, SCHOOL REPORTS, AND/OR GRADE CARDS TO HELP US ASSIST IN BETTER UNDERSTANDING YOUR STRENGTHS AND WEAKNESSES.**

Name: _____
(Last) (First) (Middle)

Birth Date: _____ Age: _____ Gender: ◯ Male ◯ Female

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: _____ May we leave a message? ◯ yes ◯ no

Mobile Phone: _____ May we leave a message? ◯ yes ◯ no

Email address: _____ May we email you? ◯ yes ◯ no

**Please note: Email correspondence is not considered to be a confidential method of communication*

Employer: _____ Position: _____
(if any)

Referred by: _____
(if any) (Relationship if applicable)

Marital Status: ◯ married ◯ single ◯ separated ◯ divorced Other: _____

FAMILY

Relationship	***Name***	***Age***	***Current Occupation/Employer***	***Highest level of education completed***
Mother				
Father				
Spouse/Partner				
Child/Sibling				
Child/Sibling				
Child/Sibling				
Child/Sibling				
Child/Sibling				

Who currently resides in the household with you? _____

EDUCATION

Please list **where** you went to school and describe your **experiences**. Please include specific institution **names, locations** and **dates/ages** when known. ***BE AS THOROUGH AS POSSIBLE.***

ELEMENTARY SCHOOL: _____

JUNIOR HIGH SCHOOL: _____

HIGH SCHOOL: _____

COLLEGE: _____

GENERAL HEALTH

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
◯ yes ◯ no
Previous/current therapist/practitioner: _____

Have you ever been prescribed psychiatric medication? ◯ yes ◯ no
Please list: _____

Are you currently taking any prescription medication? ◯ yes ◯ no
Please list: _____

Are you currently taking any over-the-counter medication (vitamins, allergy medication, etc.)? ◯ yes ◯ no
Please list: _____

How would you rate your current physical health? (please select one)
◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Excellent
Please list any specific health problems you are currently experiencing: _____

When was your last physical exam? _____
Who is your physician? _____
Do you have any past medical problems? ◯ yes ◯ no
If yes, please describe: _____

Have you had any injuries such as broken bones or head injuries? ◯ yes ◯ no
If yes, please describe: _____

Do you have any allergies? ◯ yes ◯ no
If yes, please describe: _____

Do you have any problems with vision or hearing? ◯ yes ◯ no
If yes, please describe: _____

How would you rate your current sleeping habits? (please select one)
◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Excellent
Please list any specific sleep problems you are currently experiencing: _____

Usual Bedtime: _____
How long to fall asleep? _____
Do you sleep through the night? ◯ yes ◯ no
If you wake, how long does it take to fall back asleep?
Do you often take naps? ◯ yes ◯ no
Do you have difficulty getting up in the morning? ◯ yes ◯ no
How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

Please list any difficulties you are experiencing with appetite or eating patterns: _____

Are you currently experiencing overwhelming sadness, grief or depression? ◯ yes ◯ no
If yes, for approximately how long? _____
Are you currently experiencing anxiety, panic attacks or have any phobias? ◯ yes ◯ no
If yes, when did they begin experiencing this? _____
Are you currently experiencing any chronic pain? ◯ yes ◯ no
If yes, please describe: _____
Have you had any previous involvement with the police or the courts? ◯ yes ◯ no
If yes, please describe: _____

What significant life changes or stressful events have you experienced recently? _____

What prompted you to initiate AD/HD testing? _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition			Family member
Alcohol/Substance Abuse	◯ yes	◯ no	
Anxiety	◯ yes	◯ no	
AD/HD	◯ yes	◯ no	
Depression	◯ yes	◯ no	
Domestic Violence	◯ yes	◯ no	
Eating Disorders	◯ yes	◯ no	
Obesity	◯ yes	◯ no	
Obsessive Compulsive Disorder	◯ yes	◯ no	
Schizophrenia	◯ yes	◯ no	
Suicide Attempts	◯ yes	◯ no	

_____ _____
Signature Date