ARBOR MENTAL HEALTH CENTER
ADULT PERSONAL HISTORY

IMPORTANT

If a question does not apply, write N/A. If you do not know the answer, write DO NOT KNOW.
NOTE: The information you provide is confidential and protected by law.

Client Name________________________ Age_____ DOB_________ Ethnicity__________________
Address ________________________________ City ____________ State _____ Zip __________

Writing Hand: ☐ Right ☐ Left ☐ Ambidextrous Primary Language Spoken:_______________________

Who referred you for the evaluation: ____________________ Reason: ______________________
Have you ever had neuropsychological or psychological testing completed before: ☐ Yes ☐ No
If yes, by whom?________________ When?____________ Why?_______________________

Mental Status Exam

Orientation: *Year______ Month_______________ Day______________ Time ____________ Current Location___________________*

Registration: *(name three objects and ask patient to repeat them back)* ***Apple, Table, Penny***
☐ *Apple* ☐ *Table* ☐ *Penny*

Appearance: ☐ *Casual dress, normal grooming and hygiene* ☐ *Other:_______________________*

Attitude: ☐ *Calm and cooperative* ☐ *Other:_______________________*

Behavior: ☐ *No unusual movements or psychomotor changes* ☐ *Other:_______________________*

Speech: ☐ *Normal* ☐ *Pressured* ☐ *Tangential* ☐ *Circumstantial*

Affect: ☐ *Normal range* ☐ *Depressed* ☐ *Constricted* ☐ *Flat* ☐ *Labile* ☐ *Blunted* ☐ *Reactive* ☐ *Tearful*

Mood: ☐ *Euthymic* ☐ *Irritable* ☐ *Elevated* ☐ *Anxious* ☐ *Depressed*

Thought Process and Content:
Goal-directed and logical or disorganized?_______________________________
Delusions, phobias, or obsessions/compulsions present? ☐ *Yes* ☐ *No*
Is the person suicidal and/or homicidal? ☐ *Yes* ☐ *No* *(if yes, please explain)_______________________*

____

Perception: *Any display of hallucination or delusion during the interview?* ☐ *Yes* ☐ *No*

Insight/Judgement: ☐ *Good* ☐ *Fair* ☐ *Poor*

Recall: *(have patient recall and name the three objects from earlier)*
☐ *Apple* ☐ *Table* ☐ *Penny*

History of Presenting Problem

Why are you being seen for this neuropsychological evaluation (e.g. I had a stroke, I got into a car accident and sustained a head injury, Family members say I have memory problems, ect.)?____

Approximate date problem(s) began:________________________ Are they: ☐ Getting Better ☐ Getting Worse ☐ Staying the Same

Current Neuropsychological Problems

Please check all categories that apply (examples for each are provided to assist in selection)

☐ ***ATTENTION***

Frequently missing details, making careless errors	Difficulty paying attention for long periods of time
Easily distracted	Difficulty following directions

OTHER:

☐ ***PROCESSING SPEED***

Difficulty thinking quickly	Feeling as though most people talk to fast
Taking longer to complete tasks than before	Frequently asking people to repeat themselves (not related to hearing difficulties)

OTHER:

☐ ***LEARNING & MEMORY***

Difficulty remembering recent events, names, faces, the date, ect	Difficulty learning and remembering new information
Loss of long-term memories	Forgetting to take medication

OTHER:

☐ ***EXECUTIVE FUNCTIONING***

Acting before thinking	Difficulty problem solving, or making bad decision
Difficulty following multi-step direction	Difficulty planning and organizing

OTHER:

☐ ***NONVERBAL/VISUAL SPATIAL SKILLS***

Getting lost in familiar locations	Problems driving
Inappropriate use of objects (e.g. remote as a hat)	Right-left or directional disorientation

OTHER:

☐ ***SPEECH & LANGUAGE***

The feeling that a word is on the tip of your tongue	Mislabeling items (ex. Clock vs. watch)
Reduced speech volume	Difficulty understanding others or following conversations

OTHER:

☐ **MOTOR/COORDINATION**

Difficulty buttoning a shirt	Difficulty opening medicine bottles
Difficulty with walking or balance/ recent falls	Shakiness/Tremor

OTHER:

☐ ***SENSORY***

Reduced senses of smell	Tingling sensation
Loss of feeling in part of your body	Difficulty perceiving your bodies location in space

OTHER:

☐ ***PHYSICAL PROBLEMS***

Frequent headaches	Bowel or Bladder Incontinence
Dizziness, nausea, vomiting	Shortness of Breath
Sleep Disturbance / Weight Change	Pain

OTHER:

☐ ***MOOD & BEHAVIOR***

Increased irritability	Hallucinations (visual, auditory, or olfactory)
Increased sadness / crying for unknown reasons	Increase nervousness, suspiciousness, ect.
Thoughts of harming yourself or taking your life	Discomfort in social situations

OTHER:

☐ ***RECENT LIFE STRESSORS***

Change in job	Change in marital status
Death of a loved one	Financial or legal problems
Moved to a new location	Taking care of aging or ill loved one

OTHER:

Please rate your overall stress level: ____Very Low ____ Low ____Average ____High ____Very High

What is your greatest source of stress at this time:____

Current Clinical Concerns

Please check all categories that apply

____Aggressive behaviors	____Procrastinates	____Gets teased or bullied
____Irritable or on edge	____Moody	____Argue that you are always right
____Argues with others at home/work	____Depressed	____Negative outlook on life
____Difficulty paying attention	____Very happy without cause	____Recently experienced death of a loved one
____Easily distracted	____Does not seem to have fun	____Recently lost or changed jobs
____Difficulty staying on task	____Has extreme fears or phobias	____Recently moved from home
____Poor concentration/focus	____Has threated to hurt self	____Lies or mislead others
____Poor judgement/decision making	____Has engaged in self-harm behavior	____Steals
____Impulsive	____Has attempted suicide	____Others think you drink too much
____Hyperactive/difficulty sitting still	____Has difficulty falling asleep	____Others think you use drugs too much
____Often fidgets	____Has difficulty staying asleep	____Overreacts towards others
____Needs directions repeated	____Has nightmares or night terrors	____Swears at people, things, situations
____Anxious	____Appetite/weight change	____Disrespectful to others
____Worries or ruminates	____Eating issues (over/under/purges)	____Sexually acting out
____Tearful/cries easily	____Shy around strangers	____Skips work
____Sensitive to what others say	____Low self-image/self-esteem	____Upset by family conflict
____Socially awkward or anxious	____Does not think anyone likes you	____Doesn’t get along with others
____Hair twirling/pulling	____Has excessive amounts of energy	____Often takes too many risks
____Panic attacks	____Poor hygiene	____Memory difficulties
____Avoids certain activities or places	____Doesn’t adjust easily to change	____Does not have friends
____Engages in repetitive behavior	____Works too much/too hard	____Perfectionist

OTHER:

Activities of Daily Living

Do you drive: Yes ☐ No ☐

Who does the cooking at home: Self ☐ Another person ☐

Do you manage your own finances: Yes ☐ No ☐

Do you manage your own medication: Yes ☐ No ☐

Education

	Name of School	***Last Grade Completed***	***Year of Graduation***	***Degree Achieved***
High School				
Voc/Tech School				
College				
Graduate				

Did you or do you have academic difficulties: Yes☐ No☐ If yes, please explain: ________________________________

Have you ever repeated a grade: Yes☐ No☐ If yes, what grade(s): ____________________

Have you ever been diagnosed with a learning disabilities: Yes☐ No☐ If yes, please explain: ____________________

Military

Have you served in the Military: ___Yes ___No If yes, which branch:___________________________________

Dates of Service:_____________________________________ Discharge date:____

Combat Experience:____

Disciplinary problems:____

Employment

Employer	***Start/End Date***	***Job Title***	***Full/Part Time***	***Reason for Leaving***

How many jobs have you worked in the past 3 years:_________________________

Are you presently receiving SSI, Workman Compensation, or Disability: ___ Yes ___ No If yes, since when:_______________________

Financial status: ___Stable ___Unstable and reason: ____

Medical History:

Name of physician: ______________________________________ Clinic: _______________________ Last seen on: ________________

Reason for visit:____

Known allergies: ____

NONE: Please list your currently prescribed medications: (if you need more room, please attach a piece of paper with all medications)

MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING

Please check the box to indicate any problems that have been identified as having and note (estimate) the year of diagnosis.

NEUROLOGIC	DATE	ENDOCRINE	DATE
___ Brain Injury		___ Diabetes	
___ Brain Aneurysm		___ Hypoglycemia	
___ Migraines		___ Hypothyroidism	
___ Movement Disorder		___ Hyperthyroidism (ie. Graves)	
___ Brain or Spinal Tumor		___ Parathyroid Disorder	
___ Stroke		___ Adrenal Gland Disorder (ie. Addisons)	
___ Seizures		___ Kidney Disorder	
___ Dementia		___ Cushing's Syndrome	
___ Narcolepsy		___ Low Testosterone	
___ Sleep Disorder		___ Menopause	
CARDIOVASCULAR	DATE	EAR, NOSE, & THROAT	DATE
___ High Blood Pressure		___ Dizziness (ie. vertigo, BPPV)	
___ High Cholesterol		___ Chronic Ear Infections	
___ Heart Disease		___ Swallowing Disorder	
___ Arteriosclerosis		___ Macular Degeneration	
___ Blood Disease (ie. anemia)		___ Cataracts or Glaucoma	
GENITAL-URINARY/GASTRO-INTESTIONAL	DATE	MUSCULAR-SKELETAL	DATE
___ Bowel or Bladder Incontinence		___ Amputation	
___ Colon Disease (ie. Crohn's, IBS)		___ Arthritis	
___ Regular Urinary Tract Infections		___ Degenerative Joint Disease	
___ Gastroesophageal Reflux Disease		___ Osteoporosis	
___ Pancreatitis		___ Fibromyalgia	
___ Liver Disease (ie. hepatitis)		___ Chronic Fatigue Syndrome	
ONCOLOGY	DATE	GENETIC	DATE
___ Type & Site of cancer: _______________ ___________________________________		___ Type (ie. Fragile X, Down Syndrome, Mitochondrial Disease) ______________________________________	
MENTAL HEALTH	DATE	OTHER	DATE
___ Anxiety Disorder			
___ Mood Disorder (ie. Depression, Bipolar)			
___ Psychotic Disorder (ie. Schizophrenia)			
___ Substance Use/Abuse Disorder			

Have you had any blood work or imaging (ie. CT, MRI, X-Ray) done in the past year: Yes ☐ No ☐
If yes, what was done & when: ____

Eating:

___ No Problems
___ Drooling ___ Food falls from mouth ___ Texture sensitivity ___ Gags ___Eats limited type of food
___ Increase/ Decrease in appetite- Since: ________________ Obsessed with food- Since: _______________
___ Weight gain/ loss- Since: _______ How much: _____________

Current Sleep:

___ Duration in hours per night ___Requires naps ___Midnight awakening ___Early awakening ___ Difficulty falling asleep
___ Nightmares ___ Frequency: ___ per week ___ Content: ____
As a child were you attached to any inanimate object (i.e. blanket, teddy bear, etc.)? ___ Yes ___No
If yes, what object? ____ From age: ______ to _____

UNKNOWN:

Family Medical History

Please check any diagnosis that your family members (blood relatives only) have

Medical Condition	Mother	Father	Mother's Mother	Mother's Father	Father's Father	Father's Mother	Sibling	Other
Dementia								
Seizures								
Movement Disorder (ie. Parkinson's)								
Multiple Sclerosis								
Migraines								
Stroke								
Diabetes								
Hypertension								
Cancer								
Hyper/Hypothyroidism								
Genetic Disorder								
Learning Disorder								
ADHD								
Mental Retardation								
Other: _____________________								

Mental Health History

Has you EVER received treatment for depression, anxiety, or any other emotional difficulty: (Please check all that may apply)

☐ Never received mental health treatment of any kind

OTHER

☐ Outpatient counseling

☐ Inpatient psychiatric hospitalization

☐ Pharmacological treatment (anti-depressants, anti-anxiety medications, ect)

Are you CURRENTLY receiving treatment for any of the above conditions/difficulties: Yes☐ No☐

Please list any therapists, psychologists, or psychiatrist's that you have seen or are currently seeing

Provider Name	Dates Seen	Reason for visits

Please list any psychiatric hospitalizations that you have had

Hospital	Dates	Reason for Stay

Have you ever thought about committing suicide: Yes☐ No☐ If yes, when: ____

Have you ever or do you have a plan now: ☐ Yes ☐No

Have you ever attempted to commit suicide: ☐Yes ☐ No If yes, when: __________ how: ____________________________________

Significant Trauma: (Include age at time of incident, nature of trauma and any legal details)

___ Injured in an accident: ____

___ Physical abuse ___as a child ___ as an adult Perpetrator: ____

___ Sexual abuse ___as a child ___ as an adult Perpetrator: ____

___ Emotional abuse ___as a child ___ as an adult Perpetrator: ____

___ Neglect (please explain) ____

___ Ever removed from home growing up: ____ Placed in foster care ____ Placed with other family

___ Parent or others removed from the home If yes, please explain: ____

___ Coping with divorce If yes, please explain: ____

___ Head injuries or loss of consciousness If yes, how many times: _________ Last time occurred: __________

___ Seizures If yes, frequency: ____________ Length of time they last: _________ Occurring for how long: _______

___ Pregnancy & delivery complications If yes, explain: ____

___ Alcohol or drug use during pregnancy If yes, explain: ____

___ Delays in meeting developmental milestones on time If yes, please explain: ____

OTHER:

UNKOWN

Family Mental Health History

Diagnosis	Mother	Father	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Sibling	Other
Attention Difficulties								
Learning Difficulties								
School Problems								
Behavior Problems								
Depression								
Anxiety								
PTSD								
Drug/ Alcohol Abuse								
Hallucinations/ Delusions								
Bipolar								
Eating Disorder								
Autism								
Attempted Suicide/Suicide								

Social Background

Where were born: ________________ Where were you raised: ________________ Who raised you growing up: ________________________

Adopted: YES ___ NO ___ Age of Adoption: ___

*Mother's Name:*____ Ethnicity: ________________________

What is your relationship like: ___ good ___ fair ___ poor (if poor, why):____

Father's Name ____ Ethnicity: ________________________

What is your relationship like: ___ good ___ fair ___ poor (if poor, why):____

Name of Your Siblings	Date of Birth	Full/Half/Step	Quality of Quality of Relationship		
			___Good	___Fair	___Poor
			___Good	___Fair	___Poor
			___Good	___Fair	___Poor
			___Good	___Fair	___Poor
			___Good	___Fair	___Poor

Your current relationship status: ___Single ___Dating ___Married ___Life Partner ___Separated ___Divorced ___Widowed

Name of significant other:___________________________ Length of relationship:______________

Are there any problems in your relationship currently: ___ Yes ___ No If yes, explain:____

Do you feel safe in your current relationship: ___ Yes ___ No If no, explain:____

Describe any past/former relationships:____

____

Name of Children	Date of Birth	Living in the Household	Quality of Relationship		
		__Yes __No	___Good	___Fair	___Poor
		__Yes __No	___Good	___Fair	___Poor
		__Yes __No	___Good	___Fair	___Poor
		__Yes __No	___Good	___Fair	___Poor

Is there anyone else who lives in your household: ___Yes ___No if yes, who:____

Is there anything else you want to share about your family:____

____

Exposure/Use of Substances

Please complete to the best of your knowledge

Caffeine Use: Never used ☐ Currently uses ☐ Type & how much: _____________ Quit ☐ when: _________________
Tobacco Use: Never used ☐ Currently uses ☐ Type & how much: _____________ Quit ☐ when: _________________
Alcohol Use: Never used ☐ Currently uses ☐ Type & how much: _____________ Quit ☐ when: _________________
Drug use: Never used ☐ Currently uses ☐ Type & how much: _____________ Quit ☐ when: _________________
(including prescription abuse)

Please provide any additional details on usage: ____

____

____

Legal History

Do you have any legal history (past or present court cases, arrests, probation, ect.): ___Yes ___No
If yes, please explain: ____

Are you on probation currently: ___Yes ___No
If yes, list probation officer: ____ Phone: ______________________________

Are you under guardianship: ___Yes ___No
If yes, list guardian name(s): ____ Phone: ______________________________

Additional Information

Any additional comments, questions, or requests you would like to bring to the doctor's attention: ______________________________

____

____

______________________________ ______________ ______________________________ ______________
Signature of Parent/Guardian Date Signature of Doctor Date