65 THOMAS JOHNSON DRIVE, SUITE A, FREDERICK, MD 21702

Adult History Form

Please fill out this questionnaire as completely as possible.
All information is confidential and will be protected in accordance with State and Federal law.

Client Name: ____ **Date**: __________________
Information supplied by (name and relationship to the client): ____

Full legal name : ____
Preferred nickname: _______________________________

Birth date: _____________ Age: _____
Birthplace: ____________________________

Current residential address: ____
____

Handedness: ☐ Left or ☐ Right
Sex: ______ Gender: __________
Ethnic identification: ____
Primary language: ______________________________________
Other languages spoken: _______________________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other
Name of patterner/spouse: _______________________________________

Family and Home Information: (use additional copies of this page as needed)

<table>
<tr>
<td>
First Parent/Guardian Name: ______________________
Status: Mother ___ Father ___ Other: __________________
Biological parent? ☐ Yes ☐ No
Adoptive parent? ☐ Yes ☐ No
Stepparent? ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced
Primary Language: _________________________________
Secondary Language: _______________________________
Address: City: _______________________ State: ____
Education: ___________________________
Occupation: ____
Year deceased (if applicable):_____
</td>
<td>
Second Parent/Guardian Name: ______________________
Status: Mother ___ Father ___ Other: __________________
Biological parent? ☐ Yes ☐ No
Adoptive parent? ☐ Yes ☐ No
Stepparent? ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced
Primary Language: _________________________________
Secondary Language: _______________________________
Address: City: _______________________ State: ____
Education: ___________________________
Occupation: ____
Year deceased (if applicable):_____
</td>
</tr>
<tr>
<td>
Third Parent/Guardian Name: ______________________
Status: Mother ___ Father ___ Other: __________________
Biological parent? ☐ Yes ☐ No
Adoptive parent? ☐ Yes ☐ No
Stepparent? ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced
Primary Language: _________________________________
Secondary Language: _______________________________
Address: City: _______________________ State: ____
Education: ___________________________
Occupation: ____
Year deceased (if applicable):_____Year deceased (if applicable): ________
</td>
<td>
Fourth Parent/Guardian Name: ______________________
Status: Mother ___ Father ___ Other: __________________
Biological parent? ☐ Yes ☐ No
Adoptive parent? ☐ Yes ☐ No
Stepparent? ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced
Primary Language: _________________________________
Secondary Language: _______________________________
Address: City: _______________________ State: ____
Education: ___________________________
Occupation: ____
Year deceased (if applicable):_____Year deceased (if applicable): ________
</td>
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</table>

Emergency Contact: _________________________
Telephone number: ____________________________ Relationship: ______________________________________

Additional family members (children, siblings):

Name	Age	Relationship	Living with Client?
_____________________________	___	_______________	☐ Yes ☐ No
_____________________________	___	_______________	☐ Yes ☐ No
_____________________________	___	_______________	☐ Yes ☐ No
_____________________________	___	_______________	☐ Yes ☐ No
_____________________________	___	_______________	☐ Yes ☐ No
_____________________________	___	_______________	☐ Yes ☐ No

Family Developmental/Medical/Psychiatric History

Please provide any information regarding family history of developmental disability, medical conditions, seizure disorders, emotional problems, substance abuse, psychiatric illness, and/or learning difficulties:

____

____

____

____

____

Client Developmental History:

Please complete as much of the following about the client as possible:

Number of pregnancies of mother: _______________ Which one was this client?: ____________________

Were there any complications during client's mother's pregnancy? ☐ No ☐ Yes ☐ Don't Know If "yes," please explain:

____

____

Client's Birth weight: ________ Condition at birth? Please explain ______________________________________

____

____

Milestones: Was the client's development in the following areas early, normal or delayed:

	EARLY	NORMAL	DELAYED
Standing/Walking			
Speech			
Self-Care (eating, dressing)			

Any difficulties with above? ☐ No ☐ Yes Details: ____

____

____

Client's Medical History:

Has the client had any serious: Accidents? ☐ No ☐ Yes Injuries? ☐ No ☐ Yes Illnesses? ☐ No ☐ Yes

If yes, please give details: ____

____

____

Please detail any of the client's hospitalizations:

Date	Age	Hospital	Reason	Length of stay

Client's Physician: ________________________________ Phone: ______________________________

Name of Medical Group: ____

Date of last hearing screening ______________ Location __________________ Hearing Aids ☐ No ☐ Yes

Date of last vision screening _______________ Location __________________ Glasses ☐ No ☐ Yes

If glasses, what for _________________________________

Does or did the client have lead poisoning? ☐ No ☐ Yes

If "yes," please explain: ____

Past and Current Medications taken by the client:

Date	Age	Drug	Reason	Physician

Current Health Concerns:

Respiratory
Frequent Colds ☐ No ☐ Yes Details: ______
Chronic Cough ☐ No ☐ Yes Details: ______
Asthma ☐ No ☐ Yes Details: ______
Hay Fever ☐ No ☐ Yes Details: ______
Sinus Condition ☐ No ☐ Yes Details: ______

Cardiovascular
Shortness of Breath or Dizziness with Physical Exertion ☐ No ☐ Yes Details: ______
Activity Limitation Due to Heart Condition ☐ No ☐ Yes Details: ______
Heart Murmur ☐ No ☐ Yes Details: ______

Gastrointestinal
Excessive Vomiting ☐ No ☐ Yes Details: ______
Frequent Diarrhea ☐ No ☐ Yes Details: ______
Constipation ☐ No ☐ Yes Details: ______
Stomach Pain ☐ No ☐ Yes Details: ______

Genitourinary
Urination in Pants/ Bed ☐ No ☐ Yes Details: ______
Pain While Urinating ☐ No ☐ Yes Details: ______

Musculoskeletal
Muscle Pain ☐ No ☐ Yes Details: ______
Clumsy Walk ☐ No ☐ Yes Details: ______
Poor Posture ☐ No ☐ Yes Details: ______

Skin
Frequent Rashes ☐ No ☐ Yes Details: ______
Bruises Easily ☐ No ☐ Yes Details: ______
Sores ☐ No ☐ Yes Details: ______
Severe Acne ☐ No ☐ Yes Details: ______
Itchy Skin (Eczema) ☐ No ☐ Yes Details: ______

Neurological
Seizures/ Convulsions ☐ No ☐ Yes Details: ______
Speech Defects ☐ No ☐ Yes Details: ______
Accident Prone ☐ No ☐ Yes Details: ______
Grinds Teeth ☐ No ☐ Yes Details: ______
Has tics/twitches ☐ No ☐ Yes Details: ______

Allergies
Allergies to Medicine ☐ No ☐ Yes Details: ______
Allergies to Food ☐ No ☐ Yes Details: ______
Other Allergies ☐ No ☐ Yes Details: ______

Speech
Stuttering ☐ No ☐ Yes Details: ______
Unclear Speech ☐ No ☐ Yes Details: ______
Other speech problems ☐ No ☐ Yes Details: ______

Hearing
Severe Ear Infections ☐ No ☐ Yes Details: ______
Hearing Problems ☐ No ☐ Yes Details: ______
(If yes, number of times: ______)

Client's Assessment and Treatment History:

Please include as complete a history as possible or past and current evaluations and treatment.
Include agencies, physicians, counselors, institutions, therapists, etc.

Provider	Dates (From/To):	Type of Treatment

Has the client been court involved? ☐ No ☐ Yes If "yes," please explain: ______________________________

Client Educational History:

	Years Attended	Name/Location	Graduation (Y/N)	Degree Obtained
Grade School				
High School				
College				
Post Graduate				
Post Graduate				
Post Graduate				

Did the client experience any of the following in school?

☐ Learning Problems ☐ Discipline Problems ☐ Social Problems ☐ Attention Problems ☐ Emotional Problems

If you answered, "yes," to problems at any academic level, please detail here:

____

____

____

Client Work History:

Dates	Position/Job Duties	Employer	Reason for Leaving

Please describe any history of difficulties with work: ______________________________________

____

____

____

Additional Information:

Please describe other problems: ____
____
____
____
____
____

What do you think are the client's greatest strengths? ____
____
____
____
____
____
____

Please describe goals for the client:

____
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____
____

Completed by: ____________________________________

Signature: ____ **Date:** _____________