

ADULT HISTORY-INTAKE FORM

General Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ Zip Code: _____

Home/Cell Phone: _____

Marital Status: _____ Age: _____

Occupation: _____ Work Phone: _____

Email Address: _____

Referred By: _____

Primary Doctor: _____ Phone #: _____

Address: _____

Concerns:

Please describe your primary concern(s):

Health and Medical Information:

General Medical:

Primary Care Physician: _____ Telephone: _____

Are you under the care of other medical specialists? _____

If yes, please describe:

Please describe your overall physical health:

Please provide any pertinent medical history including any testing that has been done:

Date	Type	Diagnosis	Recommendations
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Head Injury:

Have you ever had a head injury such as a concussion? _____

If yes, please describe (year, treatments):

Seizures:

Have you ever had a seizure? _____

If yes, please describe (frequency, medications):

Medications:

Please list all past and current medications and dosages:

General Health:

Has any of your immediate family member's experienced personal, social or learning problems? _____

If yes, please describe:

Have you ever suffered from a serious or debilitating illness? _____

If yes, please check from any of the following:

	Comments
Respiratory problems _____	_____
High fever _____	_____
Meningitis _____	_____
Ear infections _____	_____
Throat problems _____	_____
Asthma _____	_____
Skin Problems _____	_____
Stomach Problems _____	_____
Allergies _____	_____
Epilepsy _____	_____
Seizures _____	_____
Bedwetting _____	_____
Self-Mutilation _____	_____

Medical History:

Please check any of the following that apply to you:

- Allergies _____
- Frequent colds _____
- Dizziness _____
- Encephalitis _____
- High Fever _____
- Measles _____
- Pneumonia _____
- Tinnitus _____
- Asthma _____
- Convulsions _____
- Draining ear _____
- German Measles _____
- Influenza _____
- Meningitis _____
- Seizures _____
- Tonsillitis _____
- Chicken pox _____
- Croup _____
- Ear Infections _____
- Head aches _____
- Mastoiditis _____
- Mumps _____
- Sinusitis _____
- Others _____

If you checked any of the above conditions, please explain:

Sensory-Motor Function

Do you have fine motor difficulties? _____
If yes, please describe:

Do you have gross motor difficulties? _____
If yes, please describe:

Hand Preference

Please indicate L, R or A (ambidextrous) for the following tasks:

General _____

Throwing _____

Writing _____

Eating _____

Brushing Teeth _____

Brushing Hair _____

General Behavior

Please use the following scale to describe your overall behavior: Often, Sometimes, Rarely, Never:

Distractible: _____ Cooperative: _____ Short attention Span: _____

Organized: _____ Hyperactive: _____ Disorganized: _____

Hypoactive: _____

Few/no friends: _____

High pain tolerance: _____

Socially immature: _____

Low pain tolerance: _____

Avoidance behaviors: _____

Tics: _____

Aggressive: _____

Phobias: _____

Sound sensitive: _____

Impulsive: _____

Touch sensitive: _____

Inflexible: _____

Odor sensitive : _____

Low frustration: _____

Compliant: _____

Overreacts: _____

Please respond to the follow questions about your general behavior:

How do you typically respond to distractions?

How would you rate your response to difficult tasks?

How would you rate your level of organization?

How would you rate your listening skills?

How would you rate your attention?

Please describe your typical mood?

Person completing form:

Signed: _____ Date: _____