Green Leaf Psychological Services, Inc.
Adult History Form

Thank you for choosing Green Leaf Psychological for this assessment.

Although this questionnaire is lengthy, we ask that you take the time to complete it and return it as soon as possible. Your answers on this questionnaire combined with interviews and testing will help us determine the causes of current difficulties and will allow us to provide appropriate recommendations.

As such, the completion of this form is a required component of the assessment - we will not be able to begin writing the final report without it.

All information provided in this questionnaire will be considered strictly confidential.

Thanks again for choosing us…let's get started!

Date: _____(DD/MM/YYYY)

Name: _____
Last First Middle

Home address: _____

City: _____ Province: _____ Postal code: _____

Home phone: _____ Cell phone:_____

Email: _____

Birthday: _____(DD/MM/YYYY) Age: _____

Gender: _____ Occupation: _____

Education you have completed: ___ Elementary ___ Junior high ___ Senior high
___ University ___ Graduate school ___ Other
Level completed: _____ (e.g., 8th grade, 1st B.A., M.Sc., etc)

Birthplace: _____
City Province / State Country

If you were not born in Canada, when did you arrive in Canada? _____

Is English your primary language? ____ Yes ___ No

If no, when did you begin to communicate comfortably in English? _____

What other language(s) do you speak? _____

What other language(s) do you read and/or write? _____

Reason for this Assessment

What is your main reason for seeking an assessment?

How long has this been going on?

Why have you chosen to seek help now?

Have you had any previous assessments for this problem? If so, when? What was the main finding?

Do you have the report? ___ Yes ___ No (if "Yes", please bring it to your next appointment)

Your Occupation

Please describe the work you are doing now. If you are currently not working, please describe the work you did last.

Are you having any trouble on the job? What are the parts that are most difficult for you?

Overall, to what extent does your present work satisfy you?

What kinds of jobs have you held?

Current Education

Are you currently in school? ____ Yes ____ No

If you are currently in school, where do you go? Are you in full-time or part-time studies? How are your marks? How hard do you feel you work at your studies? What courses do you like the best / least?

Previous Education

Did you: ___ like school ___ not like school ___ feel indifferent toward school?

For each of the following, please indicate generally how you did. Please describe any special help you received (resource, guidance, accommodations, etc.):

I. Primary (Grades K-3)

II. Intermediate grades (Grades 4-6)

III. Junior High (Middle School)

IV. High School

What was your best subject? _____

What was your worst subject? _____

Did you have any problems with reading?

____ late learning to read
____ reading aloud
____ memory of material read
____ sounding words
____ reading comprehension

Other information about your reading:

Did you have problems with writing?

____ spelling
____ neatness of handwriting
____ organization of ideas
____ grammar
____ creativity (making up stories, etc.)

Other information about your written expression:

In your math work, were significant problems noted with:

____ understanding new concepts
____ timed tests
____ remembering "math facts"
____ careless errors

Other information about your math work:

How did you do in:

	Below Average	**Average**	**Above average**
Science			
History			
Music			
Gym			
Art			

Did your teachers think you did as well as you could have done?

____ performing below potential ____ working to potential ____ exceeding expectations

Did you have speech problems? If yes, describe _____

Did you receive speech and language therapy? ____ yes ___ no

Were you thought to have memory problems of any kind? ____ yes ____ no

Were you in any type of special education programming, and if so, what? ____ yes ____ no

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Were you ever retained in a grade? ____yes ____no

If so, which one(s)? _____

Did teachers say that you were:

	Yes	No	Don't know
Distractible			
Inattentive			
Daydreamy			
A poor listener			
Slow moving, slow responding			
Impulsive			
Hyperactive			
Someone who talked too much			
Someone who disturbed others in class			
Often out of your seat without permission			
A class clown			
Disorganized			
A poor time manager			
Poor at completing your work			
Unmotivated or lazy			
Someone who could not follow instructions			
Someone who had difficulty in thinking of words to say			
Under performing in school			

School Social Life

Did you have social problems as a child or teen? ____ yes ____ no

If so, please say more. For example, were you very shy around peers, aggressive, ignored, bullied, awkward, etc.?

How well did you:

	Below average	Average	Above average
Get along with brothers or sisters?			
Get along with your peers?			
Make friends?			
Maintain friendships?			

Were significant behavior problems noted? ____yes ____ no

Please describe these as best you can.

_____

_____

If you were placed in any behavioural programming, what was it?

_____

_____

Were you ever in fights at school? ____ yes ____ no

If so, approximately how many and during which grades? Who would you say started these, you or someone else?

Did you ever use a weapon in a fight? ____ yes ____ no

Were you ever:

	Yes	**No**	**Number of times**
Suspended from school			
Expelled from school			

Current Family Situation

Marital Status:

____ single ____ married ____ dating ____ separated ____ co-habitating

Please list the people you are living with: spouse, children, relatives, roommates, partner. Please list any of your children who are not living with you.

First name	Gender	Age	Relationship to you	Occupation (give grade for students)	Health (any specific problem)

How long have you and your spouse or partner been together? _____

What does he or she think about the problems you have been describing?

Do the problems affect your relationship? If so, how?

If you have children, do they seem to have any of the same problems you have been describing? Do any of your children have special needs?

During the past two years, have you experienced any of the following?

Event	Family member(s) involved and when
Death in the family	
Divorce	
Trouble with the law	
Financial trouble	
Job/school difficulties	
Serious illness	
Serious operation	
Mental illness	
Alcoholic problems	
Drug problems	
Family conflict	

Family of Origin

What was your family situation like when you were growing up? How would you describe the prevailing emotional overtones in your family when you were growing up? Were you generally happy as a child or unhappy?

Siblings:

Number of brothers: _____

Brothers' ages: _____

Number of sisters: _____

Sisters' ages: _____

Please indicate whether any of your siblings were not biologically related to you, or half-siblings to you:

Did any of your siblings have difficulties similar to the one(s) with which you are struggling?

____ yes ____ no. If yes, please describe _____

Your Parent / Caregiver 1

Is he/she living? ___ If alive, their age: _____

Deceased? ____ If deceased, age when he/she died: _____

How old were you at this time? _____

Level of education he/she earned: _____

Occupation: _____

Is this your biological parent ? ____ yes ____ no

Did he/she have difficulties similar to the one(s) with which you are struggling?

____ yes ____ no. If yes, please describe _____

Your Parent / Caregiver 2

Is he/she living? ____ If alive, their age: _____

Deceased? ____ If deceased, age when he/she died: _____

How old were you at the time? _____

Level of education he/she earned: _____

Occupation: _____

Is this your biological parent? ____ yes ____ no

Did he/she have difficulties similar to the one(s) with which you are struggling?

____ yes ____ no. If yes, please describe _____

Has any member of your extended family – parents, siblings, aunts, uncles, cousins, grandparents:

	Had trouble with paying attention
	Struggled with hyperactivity or impulsivity
	With serious behavior problems
	Experienced serious school difficulties
	Seemed much smarter than his or her achievement would indicate
	Had serious trouble with reading
	Had trouble with anxiety
	Had trouble with depression
	Suffered fro another mental illness
	Had trouble with drugs
	Had trouble with alcohol
	Had serious problems with the law

If so, please provide some information about this:

Health

How is your health generally? _____

Are you taking any medication? If so, please describe the type and purpose of the medication.

Have you ever had hearing difficulties? _____ yes ____ no

If so, have you ever used a hearing aid? ____ yes ____ no

Do you now? ____yes ____ no

Have you ever had difficulties with vision? ____ yes ____ no

If so, have glasses been prescribed? ____yes ____ no

Are they to be worn at all times, or just for certain activities? _____

Beside each item indicate how often each is a problem for you:

	Never	Less than once a year	Every few months	Once a week	2 to 3 times per week	Most days
Headaches						
Back pain						
Other aches and pains						
Rapid heartbeat						
Dizziness/light-headedness						
Stomach upset						
Mental confusion						
Blurred vision						

As far as you know, did your mother have any difficulties during her pregnancy with you?
____ yes ____ no

As far as you know, during this pregnancy, did your mother

____ take prescription medication
____ smoke cigarettes
____ drink alcohol
____ use street drugs
____ use caffeine (coffee, tea, etc.)

If yes, please elaborate:

Were there any difficulties with the delivery? ____ yes ____ no

A far as you know, did you reach physical developmental milestones (sitting up crawling, walking, using a spoon, etc.):

____ early ____ at the expected ages ____ late

As far as you know, did you reach verbal milestones (speaking single words, making short sentences, developing longer sentences)

____ early ____ at the expected age ____ late

Have you ever had:

____ allergies
____ heart problems
____ blood pressure problems
____ thyroid difficulties
____ diabetes
____ convulsions or seizures
____ a head injury
____ meningitis
____ encephalitis
____ tics
____ other diseases or illness
____ unusual physical symptoms

Other information about this: _____

_____

Please list any serious illnesses, surgeries, or hospital stays you have had. How old were you when you had this? Are any effects of the condition still present?

_____

_____

_____

_____

_____

Alcohol and Drugs

How many cups of regular (not decaffeinated) coffee, tea, or cola drinks do you drink on the average day?

Coffee ____ cups Tea ____cups Cola ____ glasses

If you smoke, how many cigarettes do you smoke on an average day?

___ 1-3
___ 4-10
___ ½ package - 1 pack
___ 1-2 packages
___ more than 2 packs

On average, how often do you have beer, wine or other alcohol?

___ every day
___ 4-6 times a week
___ 2-3 times a week
___ about once a week
___ 2-3 times a month
___ about once a month
___ less than once a month
___ not at all in the past year
___ never tried

How often would you have five or more drinks (beer, wine, or other alcohol)?

___ every day
___ 4-6 times a week
___ 2-3 times a week
___ about once a week
___ 2-3 times a month
___ about once a month
___ less than once a month
___ not at all in the past year
___ never

On average, how often do you use marijuana?

___ every day
___ 4-6 times a week
___ 2-3 times a week
___ about once a week
___ 2-3 times a month
___ about once a month
___ less than once a month
___ not at all in the past year
___ never tried

If you use, or have used any street drugs (cocaine, amphetamines), when and how often?

_____

Sleep

What time do you usually go to bed on a work or school night? _____

How long does it take before you fall asleep? _____
Is falling asleep often difficult? ____ yes ____ no

Please provide some detail:

_____

_____

After you fall asleep, do you usually stay asleep all night? ____ yes ____ no

If not, about how many times do you wake up each night? _____

Do you have trouble getting back to sleep? ____ yes ____ no

Is it normally difficult for you to wake up and get moving in the morning? ____ yes ____ no

How often are you late for school or work? _____

Are you often tired during the day? ____ yes ____ no

Do you nap during the day? ____yes ____ no

Appetite and Energy

Do you have a big appetite, an average one or a small appetite? _____

Does your mood affect your appetite? ____ yes ____ no

Please say more about this.

_____

_____

Has your weight increased or decreased recently?

____ significant increase ____ significant decrease

Were you trying to lose or gain weight? ____ yes ____ no

Currently, are you trying to gain or lose weight? ____ yes ____ no

Have you ever had an eating disorder? ____ yes ____ no

Please say more about this.

_____

How would you describe your typical energy level?

_____

_____

What kind of regular exercise do you do?

_____

_____

Mood

What is your usual mood?

___ even and stable
___ sad, blue
___ angry or irritable
___ worried or anxious
___ other _____

Please say more about this.

_____

_____

_____

Are you troubled by:

___ work stress
___ school stress
___ financial stress
___ legal stress
___ disturbing thoughts
___ social fears
___ family problems
___ anger problems

___ health problems

Please elaborate.

_____

Attention and Concentration

Beside each item below, please indicate how much of a problem each one is for you.

	Not at all	**Just a little**	**Pretty much**	**Very much**
Physical restlessness				
Mental restlessness				
Easily distracted				
Impatient				
"Hot" or explosive temper				
Unpredictable behavious				
Difficulty completing tasks				
Shifting from one task to another				
Difficulty sustaining attention				
Impulsive				
Talking too much				
Difficulty doing task alone				
Interrupting others				
Not listening to others				
Losing a lot of things				
Forgetting to do things				
Engaging in physically daring activities				
Always on the go, as if driven by a motor				

The items below refer to how you have behaved and felt DURING THE PAST WEEK, INCLUDING TODAY:

Rate each of the following using the scale below:	
Not true of me	**0**
Rarely true of me	**1**
Sometimes true of me	**2**
Often true for me	**3**
Very often true of me	**4**
Almost always true of me	**5**

___ At home, work or school, I find my mind wandering from tasks that are uninteresting or difficult.

___ I find it difficult to read written material unless it is very interesting or very easy.

___ Especially in groups, I find it hard to stay focused on what is being said in conversations.

___ I have a quick temper … a short fuse.

___ I am irritable, and get upset by minor annoyances.

___ I say things without thinking, and later regret having said them.

___ I make quick decisions without thinking enough about their possible bad results.

___ My relationships with people are made difficult by my tendency to talk first and think later.

___ My moods often have highs and lows.

___ I have trouble planning in what order to do a series of tasks.

___ I easily become upset

___ I seem to be thin skinned and many things upset me.

___ I almost always am on the go.

___ I am more comfortable when moving than when sitting still.

___ In conversations, I start to answer questions before the questions have been fully asked.

___ I usually work on more than one project at a time, and fail to finish many of them.

___ There is a lot of "static" or "chatter" in my head.

Rate each of the following using the scale below:	
Not true of me	**0**
Rarely true of me	**1**
Sometimes true of me	**2**
Often true for me	**3**
Very often true of me	**4**
Almost always true of me	**5**

___ Even when sitting quietly, I am usually moving my hands and feet.

___ In group activities it is hard for me to wait my turn.

___ My mind gets so cluttered that it is hard for it to function.

___ My thoughts bounce around as if my mind were a pinball machine.

___ My brain feels as if it were a TV with all the channels going at once.

___ I am unable to stop daydreaming.

___ I am distressed by the disorganized way my brain works.

Thank you for taking the time to complete this questionnaire.
Please return it to our office as soon as possible.