

## CLIENT HISTORY FORM

Thank you for taking the time to complete this questionnaire. The information you provide will help us assess the problems you may be having and give us important background information that is integral to our assessment. Please complete the questionnaire as thoroughly as possible but do not worry if you have difficulty with any sections as we will be going over these questions with you at your appointment. Thanks again for your time in filling out this form.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Hand used for writing:  Right  Left

Are you colour-blind?  Yes  No

Where were you born? \_\_\_\_\_

Where were you raised? \_\_\_\_\_

First Language: \_\_\_\_\_

Do you speak any other languages?  Yes  No

If yes, please indicate which ones: \_\_\_\_\_

### I) CURRENT ISSUES

Please indicate any problems you may be having from a cognitive perspective (e.g., memory, concentration or other thinking skills): \_\_\_\_\_

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Please indicate any problems you may be having from a physical perspective (e.g., physical injuries, limitations, pain, etc.): \_\_\_\_\_

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Please indicate any problems you may be having from an emotional perspective (e.g., depression, anxiety, anger or other emotional reactions):

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Do you have any problems with activities of daily living (e.g., dressing, grooming, hygiene, toileting)?  Yes  No

If yes, please describe:

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Do you have any limitations in your ability to engage in household chores (e.g., laundry, yard work, cooking, home repairs, cleaning)?  Yes  No

If yes, please describe:

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## II) EARLY HISTORY

Were you born:  Full term  Premature

If premature, how many weeks early were you born?

Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illnesses, etc.)?  Yes  No

If yes, please describe:

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Did your mother use alcohol or drugs during the pregnancy?  Yes  No  Don't Know

If yes, please explain:

Did you have any difficulties learning how to walk or talk, or with any other developmental abilities?  Yes  No

If yes, please explain:

As a child, did you have any of these conditions? (Check all that apply):

- |                                                       |                                              |
|-------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Attention Problems           | <input type="checkbox"/> Head Injury         |
| <input type="checkbox"/> Muscle Tightness or Weakness | <input type="checkbox"/> Clumsiness          |
| <input type="checkbox"/> Hearing Problems             | <input type="checkbox"/> Speech Problems     |
| <input type="checkbox"/> Frequent Ear Infections      | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Other Problems: _____        |                                              |

## III) EDUCATIONAL HISTORY

Did you finish high school?  Yes  No

If no, what grade did you leave?

If no, did you subsequently complete a G.E.D.?  Yes  No

What was your average mark in school?

What was your strong subject(s) in school? \_\_\_\_\_

What was your weak subject(s)? \_\_\_\_\_

Did you repeat any grades in school?  Yes  No Which one(s)?

If yes, what was the reason?

Did you receive any special assistance or were you in special classes in school?

Yes  No If yes, what did you receive help for? \_\_\_\_\_



- |                                                            |                                                     |
|------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Cerebral Palsy                    | <input type="checkbox"/> Pneumonia                  |
| <input type="checkbox"/> Chicken Pox                       | <input type="checkbox"/> Poisoning                  |
| <input type="checkbox"/> Colds (excessive)                 | <input type="checkbox"/> Polio                      |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Encephalitis                      | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Fevers (104 F or higher)          | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Heart Disease/ Problems           | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Kidney Problems/ Disease          | <input type="checkbox"/> Whooping Cough             |
| <input type="checkbox"/> AIDS, ARC, or HIV +               | <input type="checkbox"/> Liver Disease              |
| <input type="checkbox"/> Arterioscleroses (Artery Disease) | <input type="checkbox"/> Malnutrition               |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Parkinson's Disease        |
| <input type="checkbox"/> Blood Disorder                    | <input type="checkbox"/> Multiple Sclerosis         |
| <input type="checkbox"/> Epilepsy                          | <input type="checkbox"/> Psychiatric Problems       |
| <input type="checkbox"/> Hazardous Substance Exposure      | <input type="checkbox"/> Pulmonary Problems         |
| <input type="checkbox"/> Huntington's Disease              | <input type="checkbox"/> Radiation Exposure/Therapy |
| <input type="checkbox"/> Hypertension                      | <input type="checkbox"/> Senility (Dementia)        |
| <input type="checkbox"/> Stroke or TIA                     | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Fainting Spells                   |                                                     |
| <input type="checkbox"/> Other Disease/ Disability: _____  |                                                     |

Details:

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Have you had any surgeries?     Yes     No

If yes, please describe:

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Have you had any previous concussions or head injuries?     Yes     No

If yes, please describe:

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Please list all of your current medications:

Name of drug:

Dosage:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you drink alcohol?     Yes     No

If yes, how many drinks do you have in a typical week? \_\_\_\_\_

Have you ever had a drinking problem?  Yes  No

If yes, please describe: \_\_\_\_\_

Is there a history of alcoholism in your family?  Yes  No

If yes, who in your family had a problem?

Do you use street drugs currently?  Yes  No

If yes, please indicate which drugs: \_\_\_\_\_

Did you use street drugs in the past?  Yes  No

If yes, which ones? \_\_\_\_\_

Have you ever been dependent on or abused prescription drug(s)?  Yes  No

If yes, please describe: \_\_\_\_\_

Is there a family history of drug abuse?  Yes  No

If yes, who in your family has a problem?

Are you a smoker?  Yes  No If yes, how many cigarettes do you smoke a day?

Have you ever been under the care of a psychiatrist, psychologist, or counselor?

Yes  No If yes, what were you seen for? \_\_\_\_\_

If yes, name of doctor/ therapist: \_\_\_\_\_

How long did you receive care? \_\_\_\_\_

Is your therapy current or ongoing?  Yes  No

Did you feel treatment was helpful?  Yes  No

If no, why? \_\_\_\_\_

Have you ever thought of suicide?  Yes  No

If yes, when was the last time you thought about it? \_\_\_\_\_

Have you had a prior psychological or neuropsychological evaluation?  Yes  No

Have any of your close biological family members (parents, brothers, sisters, grandparents, aunts, uncles) had any of the following problems? (please indicate which family member had the condition if applicable):

Physical Problems

Epilepsy or Seizures

Learning Disability

Mental Retardation

Heart Problems

Hypertension

Cancer

Other: \_\_\_\_\_

Neurologic (Brain) Disease:

Stroke

Alzheimer's Disease/ Senility

Huntington's Disease

- Multiple Sclerosis
- Parkinson's Disease
- Brain Tumor
- Muscular Dystrophy
- Other: \_\_\_\_\_

Psychiatric Illness:

- Alcoholism/Drug Dependency
- Bipolar Disorder (Manic Depression)
- Depression
- Personality Disorder
- Schizophrenia
- Other Psychiatric Illness
- Speech or Language Disorder
- Other Disease/ Disorder

**VI) PSYCHOSOCIAL HISTORY**

Current marital status:  Married  Single  Divorced  Separated  Widow  
If married or common-law, how long have you been with your partner? \_\_\_\_\_

Spouse's name: \_\_\_\_\_

Spouse's occupation: \_\_\_\_\_

Do you have children?  Yes  No

If yes, please list child(ren's) name(s), age(s), and sex:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

With whom are you now living? (if not the people listed above please indicate who)

\_\_\_\_\_

What are your hobbies or what do you like to do in your spare time? \_\_\_\_\_

\_\_\_\_\_

Please indicate any treatment you are currently involved in:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate any treatment you having already completed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have had prior treatment or are currently in treatment, are your symptoms improving, staying the same, or getting worse? \_\_\_\_\_