Medical & Rehabilitation Psychology Associates

ADULT BIOGRAPHICAL & HISTORY INFORMATION SHEET

DATE COMPLETED: ______________________________ COMPLETED BY: ____________________________

PATIENT NAME/PREFERRED NAME: ____________________________ DATE OF BIRTH: _________ AGE: _____

SEX AT BIRTH: MALE FEMALE GENDER IDENTITY: _________________________________

MARITAL STATUS:
Never Married Married Significant Other Divorced Separated Widowed

NUMBER OF MARRIAGES: _______ NUMBER OF CHILDREN: ______ AGES OF CHILDREN: ______________

EMERGENCY CONTACT: _____________________________________ PHONE: ____________________________

FAMILY HISTORY:

FATHER: Age, if Living: _____ If Deceased, Age at Death: ______Cause of Death: ______________________

MOTHER: Age, if Living: _____ If Deceased, Age at Death: ______Cause of Death: ______________________

SIBLINGS: Brother/Sister Living/Deceased Age at Death: ____ Cause of Death: ______________
Brother/Sister Living/Deceased Age at Death: ____ Cause of Death: ______________
Brother/Sister Living/Deceased Age at Death: ____ Cause of Death: ______________
Brother/Sister Living/Deceased Age at Death: ____ Cause of Death: ______________
Brother/Sister Living/Deceased Age at Death: ____ Cause of Death: ______________

EDUCATIONAL HISTORY:

HIGHEST GRADE COMPLETED: __________ High School Diploma/GED/Special Ed Diploma (Circle One)

COLLEGE ATTENDED: ____ Graduated: Yes/No

Degree Obtained: ____

VOCATIONAL TRAINING: Where and What area of Specialization: ____

***EMPLOYMENT HISTORY*:**

Current Employer: ____ Job title/position held: ______________________
Length of employment: ________________

Previous Employer: ____ Job title/position held: ______________________
Length of employment: ________________

If Retired, what was your previous employment? ____
Length of employment: ________________

If Disabled, what was your previous employment? ____
Length of employment: ________________

MEDICAL HISTORY:

CURRENT PHYSICANS: ____

GENERAL PHYSICAL HEALTH AT PRESENT (circle one):
Excellent Good OK Poor Very Poor

DATE OF LAST GENERAL EXAM (W/YOUR PCP): ______________________________

DATE OF HEARING SCREENING/EXAM: ______________________________

DATE OF VISION SCREENING/EXAM: ______________________________

DATE OF NEXT APPOINTMENT WITH YOUR NEUROLOGIST OR REFERRAL SOURCE: __________

CURRENT MEDICATIONS/VITAMINS: (You may attach a list if you prefer)

NAME: ____________ PURPOSE: ______________ PRESCRIBER: ________

NAME: ____________ PURPOSE: ______________ PRESCRIBER: ________

NAME: ____________ PURPOSE: ______________ PRESCRIBER: ________

NAME: ____________ PURPOSE: ______________ PRESCRIBER: ________

PAST ACCIDENT/INJURIES: (You may attach a list if you prefer)

TYPE OF ACCIDENT/INJURY: ____________________DATE: ____________

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PAST SURGERIES: (You may attach a list if you prefer)

TYPE OF SURGERY/PROCEDURE: __________________DATE: ____________

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TYPE OF SURGERY/PROCEDURE: __________________DATE: ____________

TYPE OF SURGERY/PROCEDURE: __________________DATE: ____________

MEDICAL DISORDERS HISTORY: (Please check all that apply)

CARDIOVASCULAR:	PATIENT	FAMILY
Heart Attack	[ ]	[ ]
Heart Disease	[ ]	[ ]
Chest Pain/Angina	[ ]	[ ]
Blocked Arteries	[ ]	[ ]
By-Pass Surgery/Angioplasty	[ ]	[ ]
High Blood Pressure/Hypertension	[ ]	[ ]
Heart Beat Irregularities (A-fib)	[ ]	[ ]

GASTRO/INTESTINAL:	PATIENT	FAMILY
Chronic Stomach/Intestinal Distress	[ ]	[ ]
Ulcer(s)	[ ]	[ ]
Diverticulitis	[ ]	[ ]
Cancer (Stomach, Colon)	[ ]	[ ]
MULTISYSTEMS:		
Diabetes	[ ]	[ ]
Renal/Kidney Disease	[ ]	[ ]
Rheumatoid Disease	[ ]	[ ]
Sickle Cell	[ ]	[ ]
Glandular Disorder (Thyroid, Hormonal)	[ ]	[ ]
Reproductive System Disorder	[ ]	[ ]
Sexually Transmitted Disease	[ ]	[ ]
HIV/AIDS	[ ]	[ ]
Cancer	[ ]	[ ]
Autoimmune Disease (i.e. Lupus)	[ ]	[ ]
COVID	[ ]	[ ]
NEUROLOGICAL DISORDERS:		
Open/Closed Head Injury	[ ]	[ ]
Loss of Consciousness Yes/No		
Concussion(s)	[ ]	[ ]
Loss of Consciousness Yes/No		
Movement Disorders (Tremors/Balance)	[ ]	[ ]
Seizures/Epilepsy	[ ]	[ ]
Syncope/Fainting/Blackouts	[ ]	[ ]
Visual Disturbances	[ ]	[ ]
Sleep Disorder (Apnea, etc.)	[ ]	[ ]
Encephalitis	[ ]	[ ]
Meningitis	[ ]	[ ]
Brain Tumor	[ ]	[ ]
Headaches	[ ]	[ ]
Stroke/Pin-stroke(s)	[ ]	[ ]
Senility	[ ]	[ ]
Dementia	[ ]	[ ]
Memory Problems	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]
Speech Difficulties (Aphasia/Word finding/Stuttering)	[ ]	[ ]
Learning/Developmental Disorders	[ ]	[ ]
Attention Deficit Disorder	[ ]	[ ]
Mental Retardation/Intellectual Disability	[ ]	[ ]
ORTHOPEDIC/MUSCULAR DISORDERS:		
Fibromyalgia	[ ]	[ ]
Fractures/Dislocations	[ ]	[ ]
Spinal Disorder(s)	[ ]	[ ]
Chronic Pain	[ ]	[ ]
Bone Cancer	[ ]	[ ]
Arthritis	[ ]	[ ]
Carpal Tunnel	[ ]	[ ]
Disc Disease	[ ]	[ ]

PSYCHOLOGICAL/PSYCHIATRIC DISORDERS:	PATIENT	FAMILY
Mood Disorder (e.g. Depression)	[ ]	[ ]
Anxiety Disorder (e.g. Anxiety, Panic, Phobia, etc.)	[ ]	[ ]
Alcohol Excess/Abuse	[ ]	[ ]
Prescription Drug Abuse/Dependency	[ ]	[ ]
Recreational Drug Abuse/Dependency	[ ]	[ ]
Psychotic Episodes	[ ]	[ ]
Nervous Breakdown	[ ]	[ ]

LIFESTYLE:	Circle one:	Frequency (how often) & Amount (how much):
Cigarette Smoker	Yes/No	____
Tobacco Use (dip, snuff, etc.)	Yes/No	____
Vaping	Yes/No	____
CBD	Yes/No	____
THC/Marijuana Use	Yes/No	____
Alcohol Use (beer, wine, liquor)	Yes/No	____
Caffeine (coffee, tea, energy drinks)	Yes/No	____

Sleep Quality:

Excellent (8-9 hours nightly)   Adequate (7 hours nightly)   Inadequate (<7 hours nightly)

C-Pap or Inspire Assisted   Yes/No

Do you exercise regularly: Yes/No   Explain: ____

Do you still drive: Yes/No   If yes, do you have any navigational issues: Yes/No
(getting lost, confused, difficulty with directions)

<u>PSYCHIATRIC TREATMENT AND/OR PSYCHOLOGICAL COUNSELING HISTORY:</u>

Current History (who are you seeing now): ____

Length of Treatment: ____

Previous History (who have you seen in the past): ____

Length of Treatment: ____

Have you ever received INPATIENT psychiatric treatment?   Yes [ ]   No [ ]

If yes, when/where: ____

Have you ever been evaluated before?   Yes [ ]   No [ ]

If yes, what type of evaluation did you have? Who ordered it? Did you have any testing?

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Any other disorders/illnesses we should know about or information you would like share?

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