Lou Eckart, Ph.D.
Licensed Clinical Psychologist
22 Mill St. Suite 109
Arlington, MA 02476
781-646-6306
Fax:781-646-8101

Adult History Questionnaire

Today's date
Name
Date of Birth
Age
Address

Telephone #
E-mail address

Insurance company
Subscriber # on your insurance card
Subscriber name
Subscriber date of birth
Subscriber's employer

Primary care physician name and practice name

By whom were you referred?

Who lives with you? (List people and ages)

Please describe your concerns:

When did these problems start?

Does anyone else in your family have similar difficulties? Please explain.

What questions are you hoping the evaluation can help to answer?

Developmental History
Were you born earlier than the usual nine months gestation?

Were there any medical problems during pregnancy, or during or after your birth, that you know of?

Did you have any medical problems in childhood? Please explain.

Communication
What is your primary language? Do you speak any other languages?

As a child, were you talkative, quiet, or average?

Did you ever receive any speech therapy?

Do you currently have any concerns about your communication skills or listening skills?

Motor
Did you enjoy active play and sports as a child?

Do you remember avoiding any sports activities because you did not like them or because they were difficult for you?

Were there any sports or physical activities at which you excelled?

Describe any sports or active pursuits which you currently enjoy.

How often do you exercise?

Social
As a child, were you pretty 'typical' socially, or were you very outgoing, or shy?

Describe some activities that you enjoyed with friends as a child

Did you have difficulty making friends, or getting along with people, at any age? Please describe.

Did you ever have difficulties with impulsiveness or over-activity?

Do you currently have any concerns about your social experiences?

Medical and Health History
Have you had any serious illnesses, operations, or injuries?

Are you under the care of any medical specialists? Please be specific.
Please describe any current medical issues and treatment.

Are you experiencing any emotional difficulties which are affecting your daily functioning? If so, please describe.

Please indicate if you are having any of the following:

Trouble falling asleep
Early morning awakening
Loss of appetite
Overeating
Compulsive spending
Loss of energy or feelings of lethargy
Lack of interest in your usual activities
Depressed mood
Anxiety
Repetitive thoughts, especially about worries and fears
Fear of social situations
Periods of high energy and little need for sleep
Restlessness
Irritability
Trouble concentrating
Trouble completing tasks
Memory problems
Being excessively self-critical
Anger or rage
Excessive use of alcohol
Drug abuse
Legal problems (please describe)

Are you participating in psychotherapy?

Are you taking any medications for mental health issues?

Do you have a family history of anxiety, depression or other mood disorders, attention deficit disorder, or other mental health or behavioral health issues?

Educational History
Did you have any difficulties when you first began attending school as a child? Please describe.

What did you enjoy in school? What was easy for you?

What did you dislike? What was harder?

Did you repeat any grades?

Did you receive any special educational services? Please describe.

How would you describe yourself as a student in elementary school?

Middle school?

High school?

Did you receive a high school diploma? In what year?

Did you go on to college or other post-secondary education or training? Please describe any degrees or certificates you hold.

What is your current occupation?

How long have you held your current job?

Do you have concerns about your job? If so, please explain.

Additional Information
Please describe what you see as your strengths and best qualities.

Please use the space below to discuss any other relevant information about yourself or any other concerns which you might have.