HAWAII CENTER *for* PSYCHOLOGY

HAWAII CENTER *for* ACADEMIC ASSESSMENT
A division of Hawaii Center for Psychology

Assessment Services: Adult History Form

Welcome to Hawaii Center for Psychology and Hawaii Center for Academic Assessment!
We appreciate your care in answering *each* question as it allows us to provide the best support for you!

PATIENT INFORMATION

Date of birth: _____ **Title:** ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Legal name: _____
(First name) (Middle name) (Last name)

Gender: ❑ Male ❑ Female **Ethnicities:**_____

Form completed by: ❑ Self ❑ Other: (Name, Relationship to you):_____

CONTACT INFORMATION

Please only provide contact numbers where HCP may call to confirm appointments, leave messages via voicemail, or with anyone who answers:

Contact to schedule appointments: ❑ Self ❑ Other: **(Name, Relationship to you):**_____

Contact numbers: 1)_____ **2)** _____

Emergency contact (Name, Relationship to you):_____

Contact numbers: 1)_____ **2)** _____

Mailing Address:_____
(Street) (Apt. #)

_____
(City, State) (Zip Code)

REFERRAL CONCERNS

Who referred you for this evaluation? _____

Please describe your concerns:_____

_____

_____

When did you first notice these difficulties?_____

_____

Have you addressed these concerns through previous testing and/or services? ❑ No ❑ Yes*
***Please provide a copy of your report to assist in assessment planning.**

Name of professional:_____

Month/Year:_____ **Results/Diagnosis:**_____

FAMILY HISTORY

Birth order: ❑ Only-child ❑ Oldest ❑ Youngest ❑ Other:_____

Please answer the following questions regarding your BIOLOGICAL MOTHER:

❑ Mrs. ❑ Ms. _____

(First Name) (Last Name)

Current health: ❑ Good ❑ Fair ❑ Poor **Describe:**_____

Highest level of education obtained:_____

Job title/Place of Employment:_____

Please answer the following questions regarding your BIOLOGICAL FATHER:

_____

(First Name) (Last Name)

Current health: ❑ Good ❑ Fair ❑ Poor **Describe:**_____

Highest level of education obtained:_____

Job title/Place of Employment:_____

Marital status of your BIOLOGICAL PARENTS:

❑ Never married/In a relationship together ❑ Married

❑ Separated; How old were you at this time? _____

❑ Divorced: How old were you at this time? _____

❑ Widowed; How old were you at this time? _____

Were you adopted: ❑No ❑Yes **How old were you when you were adopted?** _____

Were you ever in the care of a foster family? ❑No ❑Yes **How old were you?**_____

In whose care were you in?_____

Place of birth (City, State/Country):_____
List all places of residence (City, State/Country) and dates (month/year):

_____

_____

Names and ages of siblings (including biological, half-siblings, and step-siblings):

Sisters:_____

Brothers:_____

Current marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse's name: ❑ Mr. ❑Mrs._____
(First Name) (Last Name)

Years married:_____

Current health: ❑ Good ❑ Fair ❑ Poor **Describe:**_____

Highest level of education obtained:_____

Job title/Place of Employment:_____

If applicable, please share the names and ages of your children: _____

_____

List all individuals currently living with you (Name, relationship to you, age):

_____

_____

Primary language:_____ **Secondary language:**_____

DEVELOPMENTAL HISTORY

To the best of your knowledge, please check all that apply regarding your mother's pregnancy:

❑ Prenatal care obtained from a physician

❑ Poor maternal health; Describe:_____

❑ Mother took medication; Describe:_____

❑ Nicotine/cigarette use ❑ Alcohol consumption ❑ Cannabis/Marijuana use

❑ Other substance:_____

❑ Other events during mother's pregnancy:_____

Gestational history: ❑ Full-term ❑ Premature* ❑ Late* ***How many weeks?**_____

Delivery: ❑ Induced ❑ Forceps ❑ Breech ❑ Cesarean

Were there any complications in perinatal history:_____

_____

During your first few years of life, please indicate whether you were formally evaluated or received services for development in these areas:

❑ Physical development (meeting height/weight milestones) ❑ Motor coordination (crawling, walking)

❑ Speech and language ❑ Self-help (dressing, eating)

❑ Toileting (day, night) ❑ Social/emotional (forming peer relationships)

❑ Other:_____

Name of professional:_____

Month/Year:_____ **Results/Diagnosis:**_____

MEDICAL HISTORY

Physician:_____ **Phone:**_____
(First name) (Last name)

Address:_____

Last medical examination (Month/Year):_____

Current physical health: ❑ Good ❑ Fair ❑ Poor **Describe:**_____

Please note medical conditions Check any that apply:

❑ **Head injuries/concussions**
❑ **Surgeries**
❑ **Hospitalizations**
❑ **Asthma**
❑ **Loss of consciousness**
❑ **Illnesses**
❑ **Seizures**
❑ **Allergies**

Please describe:

_____

_____

List ALL medications prescribed (PREVIOUS & CURRENT):

Medication	Reason Taken	Dosage/Frequency	Prescribed by	Start/End Dates

EDUCATION HISTORY

Highest level of education completed:_____

Name of School:_____

Degree/Certification Received:_____ **Date received:**_____

Are you currently attending school? ❑**No** ❑**Yes**

Name of School:_____

Program/Degree:_____ **Year in program:**_____

	Name of School Attended	Grades/Years Attended	Degree/Certification
High School:			
College/University:			
Graduate School:			
Trade School:			

Have you ever been diagnosed with a learning disorder? ❑No ❑Yes

If yes, please specify (Reading, Writing, Mathematics Disorder):_____

Diagnosed by:_____ **Month/Year of diagnosis:**_____

Have you ever received special education services during any time of your schooling? ❑No ❑Yes

If yes, please describe nature of services:_____

Have you ever received academic accommodations during any time of your schooling? ❑No ❑Yes

If yes, please describe nature of accommodations:_____

EMPLOYMENT HISTORY

Current employment status: ❑Full-time ❑Part-time ❑Unemployed ❑Student

Name of employer: _____

Job title:_____ **Number of years in position:**_____

Job responsibilities: _____