PLACE PATIENT LABEL HERE

UC DAVIS HEALTH
MIND INSTITUTE – Massie Family Clinic

ADULT PATIENT QUESTIONNAIRE

Name: ____

Birth Date:__________ **Age:** ________ **Gender:** ______ **Preferred Pronouns:**____________

Address: ______________________________ **Phone:** ____________________
Email: ____________________

Primary Care Doctor or Source of Referral
(Name):____
Address: ______________________________ Phone:____________________

Reason for Referral (What questions/concerns do you have?)
____
____
____

Family
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed
Name of Spouse or Partner: ____
Number of Children: ______ Please list ages/gender of your children: ______________________
____

Name of parents, caretaker, or other individuals that assist with medical and health care? (If applicable and with appropriate consent):____
Parent's Name: Father: __________Education and Occupation: ____________________
Mother: __________ Education and Occupation: ____________________

Patient's Education
Highest degree/grade completed: ____________ Total years of education________________
Name of School and Major:____
Name of School and Major:____
Name of School and Major:____

Patient's Employment History
Current Occupation:____________________ Length of employment:______________
Previous Occupation: ____________________ Length of employment:______________
Previous Occupation: ____________________ Length of employment:______________

Sensory Functions
Do you have difficulty with any of the following: ☐ Vision ☐ Hearing ☐ Taste ☐ Touch ☐ Smell ☐ Balance
Do you wear glasses or contact lenses for vision correction? ______________________
Do you wear a hearing aid? ____
Do you use other assistive devices: ______________________________________

Handedness ☐ Right ☐ Left ☐ Ambidextrous Writing Hand:____________________
Is there a history of left-handedness in your family? If yes, who? ______________________

Medical History (check all that apply)

☐ High Blood Pressure	☐ Diabetes	☐ Vascular disease
☐ Fatigue	☐ Multiple Sclerosis	☐ Respiratory Problems
☐ Heart Disease	☐ HIV/AIDS	☐ Thyroid Disease
☐ Arthritis	☐ Hormonal Problems	☐ Circulation Problems
☐ Cancer	☐ Lupus	☐ Autoimmune disorder: _______

Other chronic medical problems ____
Have you ever been hospitalized for a medical problem? If so, date, reason, hospital________________
____
Have you been diagnosed with a chromosomal or genetic syndrome? ______________________

Neurological History (check all that apply)

- ☐ Headaches
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Sleep Disorder
- ☐ Period of mental confusion
- ☐ Sleep Apnea
- ☐ Meningitis/other brain infections
- ☐ Other______________________

Have you ever had a head injury (TBI) or concussion? (car accident, sports, fall, fight, etc.) ________________________________
If yes, please describe: (1) date, (2) age it happened, (3) how it happened, (4) any loss of consciousness and duration (5) any treatment or hospitalization, (6) any behavior or cognitive changes after the injury? ______________________________________
____

Have you ever had any of the following neurological exams? If yes, when and what were the results?

Neurological exams

	Date	Results
☐ EEG	______________	____
☐ CT scan	______________	____
☐ PET scan	______________	____
☐ MRI/fMRI	______________	____
☐ MRA	______________	____
☐ Other___________	______________	____

Current Medications

Name	Dosage	Reason for Medication
________________________	____________________	______________________________________
________________________	____________________	______________________________________
________________________	____________________	______________________________________
________________________	____________________	______________________________________
________________________	____________________	______________________________________

Complimentary or Alternative Medicine: (Acupuncture, biofeedback, chiropractic medicine, herbs and supplements, cannabis, CBD, etc.)

Name	Dosage (if applicable)	Reason for Medication
________________________	____________________	______________________________________
________________________	____________________	______________________________________

Psychiatric /Mental Health History

Have you ever been diagnosed with a mental health condition? (anxiety, depression, bipolar, PTSD, etc.) ___________________________
____

Have you ever been diagnosed with a neurodevelopmental disorder (ADHD, autism, etc.)?_____________________________________
____

Are you currently in counseling or therapy? ______________ If yes, state reason for treatment ____________________________
Therapist name and location____ Length of treatment ___________________
Were you previously in counseling or therapy? __________ If yes, state reason for treatment ______________________________
Therapist name and location____ Length of treatment ____________________

Have you ever been admitted to inpatient psychiatric or partial hospital program? ______________________________________

Hospital/Program	Length/Dates of Admission	Reason for Admission
_____________________	____________________________	____
_____________________	____________________________	____
_____________________	____________________________	____

Are you currently taking **psychiatric medication that you have not listed above**?

Name	Dosage	Reason for Medication
________________________	____________________	____
________________________	____________________	____

Have you ever experienced significant trauma? (Physical abuse, sexual abuse, domestic violence, war, natural disaster, serious medical illness)____
____

Developmental History

Were you the product of a full-term pregnancy? ☐ Yes ☐ No ☐ Don't Know Weeks Gestation: ________________

Type of delivery ☐ Vaginal ☐ Cesarean Birth weight: ___________________

Any birth Complications? If yes, please specify____

Are you aware of any of the following in your early childhood (please check all that apply)

☐ Delayed speech	☐ Motor clumsiness	☐ Learning Problems
☐ Stuttering	☐ Fine motor problems	☐ Extreme shyness
☐ Articulation problems	☐ Behavioral Issues	☐ Trouble making friends
☐ Chronic ear infections	☐ Hyperactivity	☐ Autism/Asperger
☐ Bedwetting? -If yes, how long?	☐ Attention Problems	☐ Other: _________________

School History

Were you ever in special education program (IEP, or 504) or alternative school? ______________________

If yes, what grade(s)? ____

Did you ever receive tutoring or resource room? ________________________________

If yes, what grade(s) and subjects? ____________________________________

Ever repeat a grade(s) ___________ If yes, what grade(s)? ________________________

Ever repeat a subject? ___________ If, yes what subject and grade? ____________________

Did you have difficulty learning how to read?	☐ NO	☐ YES	____________________
Did you have difficulty with reading comprehension?	☐ NO	☐ YES	____________________
Did you have difficulty with spelling?	☐ NO	☐ YES	____________________
Did you have difficulty with math?	☐ NO	☐ YES	____________________

Were you ever diagnosed with a learning disability? ________If yes, what type______________________.

Did you display conduct or behavior difficulties in school or at home? ______________________

Did you have problems with the law in adolescents? ______________________ If yes, specify_______________

Lifestyle/Psychosocial

Do you live by yourself, with friends, roommates, or with family? ______________________

Do you have any hobbies or special interests? ______________________

Do you engage in physical exercise? ___________If yes, describe______________________

Other self-care or spiritual practices that are important to you: If yes, describe______________________

Do you have friends or family that you could turn to when you need support? ______________________

Any exposure to toxic substances at work or elsewhere? (e.g., carbon monoxide, lead, etc.) ______________________

____

Current or previous use of substances. Check all that apply.

	None	Current	Past	Amount per Week
Tobacco	☐	☐	☐	__________ # packs
Vaping/E-Cigarettes	☐	☐	☐	__________ # frequency
Beer	☐	☐	☐	__________ # bottles
Wine	☐	☐	☐	__________ # glasses
Liquor	☐	☐	☐	__________
Cocaine	☐	☐	☐	__________
Heroin	☐	☐	☐	__________
Marijuana/hash	☐	☐	☐	__________
Benzos (Valium)	☐	☐	☐	__________
Stimulants (Dexedrine)	☐	☐	☐	__________
Barbiturates	☐	☐	☐	__________
Hallucinogens (LSD)	☐	☐	☐	__________

History of alcohol dependence? ☐ Yes ☐ No

If yes, How many years? _______________Age ________________Any blackouts? ____________Any withdrawal symptoms:
(i.e., rapid. heart, sweating, etc.) ____

Any drinking related problems, such as health, family life, job, incarceration? ____
Is drinking still a problem? If no, what age did use/abuse stop? ____
Any treatment or support groups for alcohol abuse? ____________________________ # hospitalizations? ________________
Describe treatment/hospitalizations/dates: ____

History of Drug Abuse or dependence? (Prescription or non-prescription drugs) Yes ☐ No ☐
If yes, what drug(s) ____
At what age did you begin using? ___________________ How many years? ____
Any withdrawal symptoms: i.e., rapid heart, sweating, etc.: ____
Any IV drug use? Yes ☐ No ☐ If yes, any sharing needles? ____
Any drug abuse related problems (e.g., health, family life, job?) ____
Still using drug(s)? ___________ Any drug treatment? ____________ # hospitalizations? ____________________________
Describe treatment/hospitalizations/dates: ____

Family History

Is there a history of medical problems in your family? (e.g., heart disease, diabetes, arthritis, lupus, multiple sclerosis, thyroid disease, etc.). Please specify family member (e.g., father, mother, sibling, grandparent, etc.)

____
____

Is there a history of neurological problems in your family? (e.g., Alzheimer's, stroke, intellectual disability, seizures, etc.). Please specify family member (e.g., father, mother, sibling, grandparent, etc.)

____
____

Is there a history of psychiatric disorders in your family? (e.g., depression, anxiety, mental illness, schizophrenia, bipolar, etc.). Please specify family member (e.g., father, mother, sibling, grandparent, etc.)

____
____

Is there a history of learning disabilities in your family? (e.g., dyslexia, ADHD, learning problems, developmental delays, etc.). Please specify family member (e.g., father, mother, sibling, grandparent, etc.)

____
____

Is there a history of alcohol and substance abuse in your family? (e.g., alcohol, marijuana, cocaine, heroin, barbiturates, etc.). Please specify family member (e.g., father, mother, sibling, grandparent, etc.)

____
____

Please list any professionals/specialists you have consulted in the past 5 years about the concerns leading to this consultation and/or evaluation: Please provide copies of any reports or findings.

1.____
2.____
3.____
4.____

Thank you for sharing this important information.
Please bring this questionnaire, all evaluation reports, and any available school records/IEP with you to your appointment:

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