California ADHD Center for Success
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Adult ADHD History Questionnaire

Please complete the following questionnaire to give me a general understanding of the various aspects of your life. This information will be very helpful in understanding more about you and your life experiences.

Name: _____ **Birth Date**:_____ **Age:**_____ **Driver's License #:**_____

Home Address:_____

City:_____ **State:**_____ **Zip Code:**_____ **Today's Date:**_____

Home Phone: ( )_____-_____ **Cell Phone:** ( )_____-_____ **E-mail:**_____

Is it OK to receive email regarding appointments: yes/no

it OK to leave a voicemail at: **home** yes/no **mobile** yes/no **work** yes/no

Emergency Contact's name:_____ **Phone:** ( )_____-_____

Birthplace:_____**Religious affiliation:**_____ **Pronouns:** she/her he/him they/them

Reason for Seeking an evaluation at this time:

_____

_____

Have you ever been evaluated and/or diagnosed with ADHD? yes/no
If so, when and by whom?

_____

List three issues/conditions that concern you most:

- _____
- _____
- _____

When did you first notice these issues/conditions?

_____

_____

What have you already tried to resolve these issues/conditions?

_____

_____

What has helped? What has not been helpful?

_____

_____

What worries you most if things stay the way they are?

_____

_____

List the most stressful things in your life that are affecting you right now:

- _____
- _____
- _____

What would you like to see happen as a result of this evaluation?

_____

_____

Therapy History:

Are you currently receiving therapy? ☐ yes ☐ no From who? _____

When did you start therapy?_____ For what issue(s)?_____

_____

_____

Have you previously seen a therapist? ☐ yes ☐ no

If yes, what did you find **most helpful** in therapy?

_____

_____

What did you find **least helpful** in therapy?

_____

_____

Have you ever been on medication for ADHD? If so, what?

_____

_____

Have you ever tried a stimulant (even once) ☐ yes ☐ no

If yes, what did you notice?_____

Are you currently taking any medication? Please list _____

_____

List past psychiatric medications: _____

Have you ever been hospitalized for psychological problems? ☐ yes ☐ no When?_____

Where were you hospitalized?_____

Have you ever attempted suicide?_____ When?_____

How?_____

Have you had a prior psychological or neuropsychological evaluation? ☐ yes ☐ no
If yes, complete this information:

Name of psychologist:_____
Address:_____
_____
Phone:_____
Date of and reason for this evaluation:_____
Findings of the evaluation/diagnoses?:_____
_____

Family History:

Are both of your parents living? ☐yes ☐ no
Are your parents: ☐ married ☐ divorced ☐ remarried

Have either of your parents been diagnosed with ADHD? (circle) MOM DAD
Have they taken medication for ADHD? MOM DAD
If not diagnosed, do they have any characteristics that suggest ADHD? If so, what?

_____

_____

Do you have any siblings? ☐ yes ☐ no
Names and ages of brothers and sisters:

_____

_____

Do any of them have ADHD? ☐ yes ☐no If yes, who?_____
Have they taken medication? ☐ yes ☐ no

Marital History

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Current Marriage:

Date of marriage:_____ Number of years married:_____ Date of separation:_____
Date of divorce:_____ Spouse's Name:_____ Age:_____
Health:_____ Education:_____ Type of marital problems:

_____

Names and ages of children:

_____

Prior Marriage:

Date of marriage:_____ Number of years married:_____ Date of separation:_____
Date of divorce:_____ Spouse's Name:_____ Age:_____
Health:_____ Education:_____ Type of marital problems:

_____

Names and ages of children:

_____

Have any been diagnosed with ADHD?

List names of spouses or children with the following problems:
Developmental/Learning problems:

_____

Emotional/Behavioral problems:

_____

Alcohol/Drug abuse:

_____

Medical Problems:

_____

Educational History:
Current grade (Or Highest grade/degree completed):_____ Current school:_____
Last grade completed: ☐ High School Diploma ☐ GED ☐ Vocational Training ☐ College_____

Hardest subject(s):_____ Favorite subject(s):_____
Grades earned in elementary school:_____ Junior High G.P.A._____
High School G.P.A._____ College GPA_____ Grades repeated:_____

Do you have any learning challenges? (ADHD, Learning Disability, Dyslexia, etc.)

_____

Learning problems (what subjects):

_____

Do you currently or have you had an: ☐ IEP ☐ 504 ☐ GATE Program
Special education placement (Type):_____ During which grades:_____
Extracurricular activities (Music, Sports, Clubs, etc.)

_____

Expulsions/suspensions/conduct problems (Type of problem and date):

_____

Additional schooling or non-academic training:

_____

<u>Elementary School</u>
Describe your experience in Elementary school:

_____

_____

Did you find school easy? Hard?

_____

Did you get into trouble in school? If so what kind?

_____

Were you ever expelled? ☐ Yes ☐ No
Did you ever repeat a grade? ☐ Yes ☐ No Skip a grade? ☐ Yes ☐ No

Did your parent need to help you with homework?

_____

Did your parent need to redirect you to stay on track with your homework?

_____

Did you have friends in Elementary school?

_____

Middle School

Describe your experience of middle school including friendships, workload and study habits.

_____

_____

Were you involved in any activities?

_____

Did you have difficulty getting homework completed?

_____

Did you choose not to do homework?

_____

Did you ever do it but forget to hand it in?

_____

High School

Describe your experience of high school.

_____

_____

What was the workload like for you?

_____

Did you take any honors, IB or AP classes?

_____

What was your experience with Homework? (eg., too much, didn't do it, worked late into night, etc)

_____

Did you participate in any sports or clubs?

_____

Did you have a 504 or IEP at any time in school?

_____

College

Did you attend college? ☐ yes ☐ no

Where did you attend college?

_____

What was college like for you?

_____

What was your major?

_____

Did you complete your degree? ☐ Yes ☐ No How long did it take?_____
If you did not complete your degree, how long did you attend?_____
Why did you discontinue your studies?

_____

Did you have any accommodations? ☐ Yes ☐ No

_____

Did you go to graduate school? ☐ Yes ☐ No
What type of degree did you earn? _____

Occupational History

Are you working? ☐ Yes ☐ No
Present employer:_____ Position:_____
Length of Employment:_____ Hours worked per week:_____
Do you enjoy your job? yes/no
Current responsibilities:_____
List previous employment for last ten years (Include type of work):

_____

_____

_____

_____

_____

Have you ever been terminated from a job (please explain):

_____

_____

_____

Legal History

Present legal problems (Describe):

_____

Past arrest (For what?):

_____

Convictions (For what?):

_____

Time served in Juvenile hall, hail or prison (give dates and locations):

_____

Military Service

Branch of service:_____ Dates of service:_____

Job(s) within service:

_____

Highest rank:_____ Rank at discharge:_____ Discharge status:_____

Social History:

List some of the good qualities you like about yourself:

_____

_____

What do you like to do in your free time?

_____

_____

Are you dating? ☐ Yes ☐ No Are you currently in a relationship? ☐ Yes ☐ No

Do you have a history of trauma? (i.e. sexual assault, been in an accident, witnessed violence, history of physical abuse, emotional abuse) ☐ Yes ☐ No If so, what happened?_____

Lifestyle Behaviors

Do you have any current physical concerns or chronic health conditions? ☐ Yes ☐ No

Please describe:

_____

_____

What medications do you take, including vitamins, natural products, etc:_____

_____

Do you take your prescribed medications daily? ☐ Yes ☐ No

Do you suspect you may misuse any prescription medication? ☐ Yes ☐ No

How would you describe your current physical health? ☐ very healthy ☐ mostly healthy ☐ moderately healthy ☐ often sick ☐ almost always sick

How well do you sleep? ☐ very well ☐ pretty well ☐ ok ☐ poorly

I sleep: ☐ too much ☐ not enough ☐ have trouble falling asleep ☐ have trouble staying asleep

How often do you exercise? ☐ daily ☐ couple of times a week ☐ occasionally ☐ rarely

What do you do for exercise? _____

Do you drink caffeine? ☐ Yes ☐ No

If so, what (soda, coffee, etc.)?_____

Do you have any concerns around your eating habits? ☐ Yes ☐ No

If yes, please describe:_____

_____

Drugs/ Alcohol History:

Do you currently use alcohol? ☐ Yes ☐ No

If yes, how often? ☐ daily ☐ 1-2x weekly ☐ socially ☐ occasionally ☐ rarely

If so, how much and what do you typically drink?

_____

Do you currently smoke marijuana? ☐ Yes ☐ No

If yes, how often? ☐ daily ☐ 1-2x weekly ☐ socially ☐ occasionally ☐ I've tried it

Have you ever smoked cigarettes? ☐ Yes ☐ No Do you currently smoke? ☐ Yes ☐ No

If so, how much per day?_____

Have you ever/ do you engage in any of the following: ☐ vape ☐ chew tobacco ☐ electronic cigarettes
☐ Other_____

Where and when do you typically use?_____

What does using do for you?_____

_____

Does your personality change when you drink? ☐ Yes ☐ No How?_____

Have you ever felt you have needed to cut down on alcohol/pot/substance use? ☐ Yes ☐ No

Have you ever felt annoyed by criticism from others about your alcohol/pot/substance abuse? ☐ Yes ☐ No

Have you ever felt guilty about your alcohol/pot/substance abuse? ☐ Yes ☐ No

Have you ever used alcohol/pot or another substance to get the day started? ☐ Yes ☐ No

Who in your family (now or in the past) has had a problem with drugs of alcohol?_____

Specify substances you currently use (Even if only occasionally or in small amounts):

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Barbiturates ("Downers") ☐ Tranquilizers
☐ Amphetamines ("Speed") ☐ Crank ☐ Crack ☐Cocaine
☐ Opiates (Heroine, Opium, Codeine, etc.) ☐ Hallucinogens (LSD, STP, "Magic Mushrooms", etc.)
☐ PCP ("angel dust") ☐ Other:_____

Specify substances you have taken in the past (Even if only occasionally or in small amounts):

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Barbiturates ("Downers") ☐ Tranquilizers
☐ Amphetamines ("Speed") ☐ Crank ☐ Crack ☐Cocaine
☐ Opiates (Heroine, Opium, Codeine, etc.) ☐ Hallucinogens (LSD, STP, "Magic Mushrooms", etc.)
☐ PCP ("angel dust") ☐ Other:_____

Place a check to indicate if any problems apply currently (in the last 6 months) or in the past.

Now	Past	
		Suicidal thoughts
		Depression/sadness
		Recurrent/intrusive thoughts
		Difficulty Sleeping
		Overeating
		Weight Gain
		Visual/Auditory hallucinations
		Anorexia/Bulimia
		Rapid mood changes
		Decreased need for sleep
		Distractible

		Fatigue
		Poor self esteem
		Overwhelming need to perform certain behaviors/rituals
		Significant concerns with physical problems
		Homicidal thoughts
		Anxiety/ nervousness
		Nightmares
		Loss of appetite
		Weight Loss
		Sexual Problems
		Apathy
		Explosive anger
		Euphoria (feel on top of the world)
		Racing thoughts
		Feeling worthless
		Loss of interest in almost all activities
		Feelings of hopelessness
		Recurrent/intrusive disturbing recollections or dreams
		Excessive fears or phobias
		Other Problems:_____

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past

Now	Past	
		Death of spouse
		Death of family member
		Illness of family member
		Illness of friend
		Personal injury/illness
		Marital difficulties

		Marital separation
		Divorce
		Sexual difficulties
		Conflicts with family
		Conflicts with friends
		Conflicts at work
		New job
		Job termination
		Retirement
		Business difficulties
		Academic difficulties
		Financial problems
		Change in residence
		Legal problems
		Sexual assault
		Incest/sexual abuse
		Physical abuse
		Verbal/ emotional abuse
		Other problems:_____

Other

Is there anything else that is important for me to know about you that has not yet been asked or expressed? If yes, please explain here:

_____

_____

_____

_____