SOUND PSYCHOLOGY
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Patient History Questionnaire

Date: _____ Date of Birth: _____

Name of Client: _____ Current Age: _____
Other last names in the past _____

S.S. #: _____ Handedness: _____R L_____

Home Address: _____ Home Phone: _____

Work Address: _____ Work Phone: _____

Referral Information:
Referred by: _____ Physician _____ L&I _____ Voc Counselor
_____ Attorney _____ DVR _____ DSHS
_____ SSI _____ Other

Name: _____
Title _____
Address _____

Phone _____

Medical History:	Yes	No	Dates
Problems with birth/early development	__	__	_____
Loss of Consciousness	__	__	_____
Seizures	__	__	_____
Motor Vehicle Accidents	__	__	_____
Major falls or industrial injuries	__	__	_____
Stroke	__	__	_____
Diabetes, heart disease, or cancer	__	__	_____
Back or neck injury	__	__	_____
Major Surgeries	__	__	_____
Other: _____	__	__	_____
Psychiatric Problems	__	__	_____
Drug/alcohol abuse	__	__	_____

Have you participated in psychiatric treatment? _____
When and Where? _____

Medication_____

Dates _____

Have you participated in drug or alcohol treatment? _____
When and Where? _____

What drugs had you abused? _____

Have you ever been cited for DWI? _____ When: _____
Loss of license? _____

What is your current drug or alcohol use ? _____

The following refer to a MAJOR accident, injury, or illness:

Date of onset: _____
Briefly describe the circumstances of the incident _____

Did you loss consciousness? _____ If so, how long? _____
Were you hospitalized? _____ If so, how long? _____

Problems following the accident, injury, or illness:
Physical difficulties or complications _____

Changes in vision, hearing, taste, or smell _____
Problems with sleep _____
Changes in sexual activity _____

Current medications:

Name	Reason for taking	Amount	Date started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Physician _____

Chiropractor _____ Last seen _____
Physical Therapist _____ Last seen _____
Neurologist _____ Last seen _____
Other _____ Last seen _____

Problems with thinking or remembering since the accident or injury _____

Explain _____

When were there problems first noticed? _____

Problems with speaking or comprehension of speech _____

Problems with visual confusion or getting lost _____

Changes in reading, spelling, or math _____

Described changes in your personality since the accident or injury _____

Have others commented on the changes? _____

Have your relationships with people changed? _____

Have there been changes in any of the following since the injury? Described briefly.
Martial/Family _____

Financial/Legal _____
Comment on the ability to handle money _____

Daily activities (include household, driving) _____

Work/Employment Status
Were you employed at the time of the injury? _____
If so where? _____

How much time after the injury did you return to work _____
Did your duties/responsibilities change? _____
Has your work been reviewed since the injury? _____
Do you consider your work to be stable? _____
Additional comments _____

Have you participated in any of the following since the injury? Describe briefly, give dates:

Psychological Counseling _____

Cognitive treatment _____

Vocational intervention _____

Neuropsycholocial testing _____

Family History	**Circle one**	**Where living**	**Occupation**
Mother	Alive/Dead	_____	_____
Stepmother	Alive/Dead	_____	_____
Father	Alive/Dead	_____	_____
Stepfather	Alive/Dead	_____	_____

Circle One	**Age**	**Where living**	**Occupation**
Sister/Brother	__	_____	_____
Sister/Brother	__	_____	_____
Sister/Brother	__	_____	_____
Sister/Brother	__	_____	_____

Marital Status:
____Married ___Never Married __Divorced __Separated __Widowed __Unmarried partner

Name of spouse/partner_____
How long married _____
Or in current relationship

Dates of previous marriages From _____ to _____
Or relationships From _____ to _____

Children (include stepchildren):

Name _____Age _____ Where living _____
Name _____Age _____ Where living _____
Name _____Age _____ Where living _____
Name _____Age _____ Where living _____

Do family members have any significant health concerns/special needs: Describe briefly

Have you ever participated in marriage/family counseling? Describe briefly.

Educational History

Highest grade completed _____ Estimated GPA _____
Do you have a high school diploma? _____If not, do you have a GED? _____
Date_____ Date _____
Did you have problems learning to read? _____
Were you in special education classes? _____

Name of high school _____ Location _____ Dates _____

School after high school: _____Location _____Date_____

Degrees/Certificates: _____

Vocational Information
Current employment _____ since _____
Duties _____
Monthly Wage _____

Past Employment:

Employer	Dates	Duties	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Source of income other than employment _____ $_____monthly

_____ $_____monthly

_____ $_____monthly

Vocational Strengths _____

Vocational Weakness _____

Military Service
Branch of military _____ Dates _____
Duties _____
Certifications, etc. _____
Rank at discharge _____Honorable discharge? _____

Legal History
Have you ever been arrested? _____ If so, how long? _____

Were you jailed or imprisoned? _____If so, how long? _____
Additional Comments _____

Current Goals (Describe briefly)

Any additional information that you may feel would be helpful for your evaluation