



William J. Mace, Ph. D.  
Adult Information Form

Patient's Initials: \_\_\_\_\_

The information you provide is for professional use only. Please answer all questions to the best of your ability.

**Patient's Full Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cellular \_\_\_\_\_ Email \_\_\_\_\_

General Physician \_\_\_\_\_ Referred By \_\_\_\_\_

As a means to do our best to help you, please explain your expectations regarding Focus-MD. What do you hope to accomplish? What do you expect to gain from your visits? \_\_\_\_\_

**FAMILY**

Relationship status: (circle all that apply)

Cohabiting Dating Married Separated Divorced Never married Living together Engaged

Length of time in current relationship: \_\_\_\_\_

Partner's age: \_\_\_\_\_ Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please fill in the names and ages of children and indicate if they are from previous relationships

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Others living in home: \_\_\_\_\_

Parents' marital status: Single Married Separated Divorced Never married

Parents divorced? \_\_\_\_\_ If yes, your age at the time \_\_\_\_\_

Mother:  Still living  Deceased, your age at the time? \_\_\_\_\_

Mother's education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father:  Still living  Deceased, your age at the time? \_\_\_\_\_

Father's education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name	Age	Any related difficulties?
Siblings: _____	_____	_____
_____	_____	_____

Tell anything else about your family in the space below that you think would be helpful for me to know.

\_\_\_\_\_



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**BIO-MEDICAL HISTORY**

List any physical or medical conditions that affect your functioning: \_\_\_\_\_

What aches, pain, or physical discomforts have you experienced recently? \_\_\_\_\_

Do you have any significant medical conditions? If yes, please describe. \_\_\_\_\_

When was the date of your last medical check-up? \_\_\_\_\_

Have you had a recent blood workup? \_\_\_\_\_ Any significant findings? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ If yes, how often? \_\_\_\_\_

Have you ever experienced a significant accident (i.e. wreck, concussion, serious injury)? \_\_\_\_\_

Surgical Operations? \_\_\_\_\_

Family history of mental illness/substance abuse/learning disabilities? \_\_\_\_\_

Please list all medications that you are currently taking including natural supplements:

Name	Frequency	Dosage	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you or did you use any of the following?

Alcohol

How much \_\_\_\_\_ How often \_\_\_\_\_ Age at first use: \_\_\_\_\_

Recreational drugs Type(s): \_\_\_\_\_

How much \_\_\_\_\_ How often \_\_\_\_\_ Age at first use: \_\_\_\_\_

Tobacco Products? Type(s): \_\_\_\_\_

How much \_\_\_\_\_ How often \_\_\_\_\_ Age at first use: \_\_\_\_\_

Circle the caffeine products you consume regularly:

Tea   soft drink   energy drink   chocolate   medications w/ caffeine

Total average of cups/mgs daily \_\_\_\_\_ At what times throughout the day? \_\_\_\_\_



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Please check all that apply for current or past:

	Current	Past		Current	Past
Headaches			Dizziness		
Stomach Problems			Sleep Issues		
Memory Problems			Confusion		
Paranoia			Impulsive Behavior		
Depression			Mood Swings		
Euphoria			Binging		
Unable to Enjoy Life			Recurring Thoughts		
Excessive Energy			Unusual Thoughts		
Weird Feelings			Weight Loss		
Weight Gain			Poor Concentration		
Worthlessness			Hopelessness		
Helplessness			Low Energy		
Crying a lot			Irritable Mood		
Legal Problems			Financial Problems		
Suicidal Thoughts			Homicidal Thoughts		
Worried a lot			Phobias		
Fears			Panic Attacks		
Grades Dropping			Anger Problems		

**PRESENTING PROBLEM**

In your own words, what are the problems or difficulties you are experiencing? \_\_\_\_\_

\_\_\_\_\_

What has been tried on your own to help with the difficulties? \_\_\_\_\_

\_\_\_\_\_

When did these difficulties first begin? \_\_\_\_\_

Does the difficulty occur at home? \_\_\_\_\_ Work? \_\_\_\_\_ Other? \_\_\_\_\_

Have you tried to get any previous help for this? \_\_\_\_\_ What kind? \_\_\_\_\_

Where? \_\_\_\_\_ Was this helpful? \_\_\_\_\_ How? \_\_\_\_\_

Have you ever had a psycho-educational evaluation? \_\_\_\_\_ If so, what tests were given? \_\_\_\_\_

Results/Recommendations? \_\_\_\_\_



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Who performed the assessment? \_\_\_\_\_ When? \_\_\_\_\_

Any other evaluations? \_\_\_\_\_ If so, what tests were given? \_\_\_\_\_

Who performed the assessment? \_\_\_\_\_ When? \_\_\_\_\_

Results/Treatment? \_\_\_\_\_

Have you ever had therapy or counseling? \_\_\_\_\_ When? \_\_\_\_\_ How long? \_\_\_\_\_

If yes, counselor's name \_\_\_\_\_

What changes have you noticed recently in your behavior and/or mood (if applicable)? \_\_\_\_\_

Who is a part of your emotional support system?

Family: \_\_\_\_\_

Friends: \_\_\_\_\_

Other: \_\_\_\_\_

What do you consider your strengths? \_\_\_\_\_

What hobbies/activities do you enjoy?

Do you ever have trouble relating to your peers? \_\_\_\_\_ Or, feel unsure in social situations? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

### SCHOOL HISTORY

Briefly list the highest level of formal education you have obtained and any other relevant education, certifications, or specialized training: \_\_\_\_\_

Your grades:  Above average  Average  Below Average  Variable

In what subjects do/did you earn your highest grades? \_\_\_\_\_

In what subjects do/did you earn your lowest grades? \_\_\_\_\_

Did you ever repeat/skipped a grade? (explain) \_\_\_\_\_

What are/were your favorite subjects? \_\_\_\_\_



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Do/did you experience problems with homework? \_\_\_\_\_ How? \_\_\_\_\_

Do/did you experience problems with tests? \_\_\_\_\_ How? \_\_\_\_\_

What other special school problems did you experience? \_\_\_\_\_

**WORK HISTORY**

Are you employed? YES \_\_\_\_\_ NO \_\_\_\_\_

Current job title/employer: \_\_\_\_\_

Briefly list past work experience: \_\_\_\_\_

Years in current position \_\_\_\_\_ Are you having any difficulties/stressors in your current job?

If so, please briefly describe those difficulties:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_