ITS Integrated Therapy Solutions

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Office Use:
Last Name: ___________________
Evaluation Date: _______________
Evaluation Time: _______________

CONFIDENTIAL PERSONAL HISTORY FOR ADULTS

Today's Date: _______________

Client Name: ____
Last Name, First Name

Address: ____ Birthdate: _____/_____/_____

____ Age: ____________________

Profession: ____

Home Phone Number: _____________________________ Sex: ☐ Female ☐ Male

Work Phone Number: _____________________________ Cell Phone Number: __________________________

Email: ____

Languages spoken in the Home: ____

REFERRAL INFORMATION:

Referred By ____ Phone #: ________________________
Family, Physician, Other Professional

____
Street Address City State Zip

May we send a thank you letter to your referral source? ☐ Yes ☐ No

Integrated Therapy Solutions has my permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation. No other information will be released without written consent.

Signature: ____ Date: _____/_____/_____

Reason (s) for your interest in having an assessment:

____

____

____

____

PERSONAL INFORMATION:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ other: ______________________________

Name of Spouse: ____

Names and ages of your children:

Name	Age	Sex	(N = Natural A = Adopted S = Stepchild F= Foster)
______________________________	_____	_____	______
______________________________	_____	_____	______
______________________________	_____	_____	______
______________________________	_____	_____	______

Please describe your current job or status as a student: ____

____

____

Are you content with your current situation at home, work, or school? _____________________________________

____

____

DEVELOPMENTAL HISTORY

Please answer these questions as best you can about your own developmental history.

FAMILY BACKGROUND

(N = Natural, A = Adopted, S = Stepchild)

	Name	Age	Education/Occupation	Handedness	
Father:	____________________________	_____	________________________________	R	L
Mother:	____________________________	_____	________________________________	R	L
Siblings:	____________________________	_____	N A S ___________________________	R	L
	____________________________	_____	N A S ___________________________	R	L
	____________________________	_____	N A S ___________________________	R	L
	____________________________	_____	N A S ___________________________	R	L

Please describe any outstanding events which occurred during your mother's pregnancy, labor and delivery or other details regarding your birth experience: ____

____

____

Were you adopted? ☐ Yes ☐ No If yes, at what age? _____________

Please describe any information you have about events preceding and following the adoption: _________________

____

____

Please describe any outstanding events which occurred before school age (problems in motor development, health, language acquisition, major moves of the family, separation of parents, any traumatic events, etc.) _____________

____

____

____

SCHOOL

Please outline any difficulties encountered at school: ____

____

____

____

HEALTH

Are you in good general health at the present time? ☐ Yes ☐ No

Are you taking any kind of prescribed medication? ☐ Yes ☐ No

Name	Dose	Frequency
______________________	______________	____________
______________________	______________	____________
______________________	______________	____________
______________________	______________	____________

List any major health problems, operations and/or illnesses you have had in the past: ________________________

____

____

____

Have you suffered or are you presently suffering from any hearing or ear-related problems? ☐ Yes ☐ No

If yes, please describe: ____

____

____

Are you currently involved in any kind of therapy? ☐ Yes ☐ No

If yes, please describe: ____

____

____

Do you have any of the following?	Rarely	Sometimes	Often	Comments
Absent-Minded	______	________	_____	______________
Easily bored	______	________	_____	______________
Difficulty getting organized	______	________	_____	______________
Difficulty sleeping	______	________	_____	______________
Frequent tiredness	______	________	_____	______________
Difficulty regulating eating habits	______	________	_____	______________
Difficulty relaxing	______	________	_____	______________
Moodiness	______	________	_____	______________
Do you enjoy speaking in public?	______	________	_____	______________
Do you play a musical instrument?	______	________	_____	______________
If you do, which one(s)	______	________	_____	______________

HBOT

Do you have any of the following?

Ear Problems	☐ Yes ☐ No	Congestion	☐ Yes	☐ No
Ear trouble while flying	☐ Yes ☐ No	Sinus Problem	☐ Yes	☐ No
Seizure Disorder	☐ Yes ☐ No	Allergies	☐ Yes	☐ No
Diabetes/hypoglycemia	☐ Yes ☐ No	Chronic Lung diseases	☐ Yes	☐ No
Communicable Diseases	☐ Yes ☐ No	Do you smoke?	☐ Yes	☐ No

Have you traveled by airplane in the past 24 hours? ☐ Yes ☐ No

Do you plan to travel by air within the next 24 hours? ☐ Yes ☐ No

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OTHER

Is there any other information you believe might be helpful to us in determining the suitability of our program for you? ____

____

____

____

GOALS/OUTCOMES

Please be specific with regard to the goals and outcomes you would like to achieve. How will you measure or evaluate the success of achieving your goals?

Goals/Outcomes	How Measured?
1. ________________________________	________________________________
________________________________	________________________________
2. ________________________________	________________________________
________________________________	________________________________
3. ________________________________	________________________________
________________________________	________________________________
4. ________________________________	________________________________
________________________________	________________________________