



Office Use:
Last Name: _____
Evaluation Date: _____
Evaluation Time: _____

STAR Center
5420 S Quebec St., Suite 103
Greenwood Village, CO 80111
Phone (303) 221-STAR (7827)
Fax (303) 322-5550

CONFIDENTIAL PERSONAL HISTORY FOR ADULTS

Today's Date: _____

Client Name: _____

Address: _____ Birthdate: _____

Age: _____

Profession: _____

Phone numbers: (H) _____ (W) _____ (C) _____

Referred by: _____
Name Address Profession

May we send a thank you letter to your referral source? ____yes ____no

STAR Center has my permission to send a thank you letter to my referral source indicating that I have been seen for an evaluation. No other information will be released without written consent.

Signature: _____ Date: _____

Reason(s) for your interest in having an evaluation: _____

PERSONAL INFORMATION

Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Name of Spouse: _____

Names and ages of your children:

Name	Age	(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	
Father _____	_____	_____	
Mother _____	_____	_____	
Siblings _____	_____	N A S	_____
_____	_____	N A S	_____
_____	_____	N A S	_____
_____	_____	N A S	_____

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.)

DEVELOPMENTAL PROFILE (School Age)

Thinking back on your childhood, please describe your motor abilities (e.g. riding a bike, throwing and catching ball, handwriting, running, etc.)

SCHOOL

Please outline any difficulties encountered at school (academic, social, etc.).

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: _____

How do you spend your leisure time? (hobbies, activities, clubs, community involvement)

Please check how each item describes you best:

	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 yes, which one(s)?	_____			

SENSORY HISTORY

Please check any that apply:

___ I seem to be overly sensitive to sensory experiences more so than most people:
___ audibly ___ tactile ___ visual ___ movement ___ taste ___ smell

___ I don't seem to react to sensory experiences as readily as most people:
___ audibly ___ tactile ___ visual ___ movement ___ taste ___ smell

___ I actively seek out sensory experiences more so than most people:
___ audibly ___ tactile ___ visual ___ movement ___ taste ___ smell

___ I have difficulty differentiating sensory experiences.
(ex. confuse sounds, can't find objects in drawer or bag without looking, bumps into things)
Describe: _____

___ I have trouble learning new movements.

___ I tend to be clumsy and have balance and coordination problems.

OTHER

Is there any other information that would 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) _____ _____	_____ _____