Adult Intake

Patient's Name: _____ Date: _____

Address: _____
(Street) (City) (State) (Zip)

Phone Number: _____
(Home) (Work) (Cell)

Age: _____ Date of Birth: _____ Sex: (check one): Male _____ Female _____

Ethnic or Racial Background: _____

Primary Language: _____ Secondary Language: _____

Education/Degree: _____

Hand used for writing/drawing: Right: _____ Left: _____ Both/Switches between hands: _____

Have you ever had a neuropsychological/psychological evaluation in the past? Yes _____ No _____

REASON FOR REFERRAL:

Briefly describe the reason for your visit: _____
_____
When did the problem begin? _____
Who referred you for this evaluation? _____
Medical diagnosis (if any):
(1) _____
(2) _____
(3) _____
What specific questions would you like answered by this evaluation?
(1) _____
(2) _____
(3) _____

THIS FORM HAS BEEN COMPLETED BY: Patient ☐ Other ☐ If other, please complete:

Name: _____ Relationship to Patient: _____

Address: _____

Phone Number: _____
(Home) (Work) (Cell)

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HISTORY OF PRESENT ILLNESS:

Briefly explain the circumstances or events which resulted in your condition: _____

_____

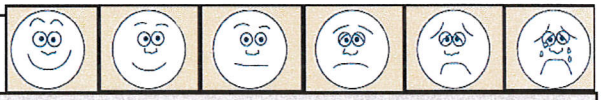
_____

_____

SYMPTOM ONSET:

Overall, my symptoms have developed:	Slowly	☐	Quickly	☐
Generally, my symptoms occur:	Occasionally	☐	Often	☐
Over the past 6 months the symptoms have:	Stayed Same	☐	Worsen	☐

SYMPTOM SURVEY:

For each of the areas below, please circle the level of difficulty you are experiencing.											
ATTENTION & CONCENTRATION:											
Difficulty with attention and concentration?	0	1	2	3	4	5	6	7	8	9	10
Easily distracted?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10
SPEED OF INFORMATION PROCESSING:											
Thinking feel slow or bogged down?	0	1	2	3	4	5	6	7	8	9	10
Need more time to figure things out?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10
SPEECH AND LANGUAGE SKILLS:											
Difficulty finding the right word(s) to say?	0	1	2	3	4	5	6	7	8	9	10
Is speech slurred or garbled?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10
SPATIAL ABILITIES & NON-VERBAL SKILLS:											
Difficulty with directions; get lost easily?	0	1	2	3	4	5	6	7	8	9	10
Difficulty recognizing people, familiar objects or places?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10
MEMORY:											
Experiencing forgetfulness?	0	1	2	3	4	5	6	7	8	9	10
Forget events that happened recently (i.e. last meal)?	0	1	2	3	4	5	6	7	8	9	10
Forget events that happened long ago (i.e. months/years)?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10
PROBLEM SOLVING:											
Difficulty figuring out how to do new things?	0	1	2	3	4	5	6	7	8	9	10
Difficulty planning ahead?	0	1	2	3	4	5	6	7	8	9	10
Difficulty keeping organized?	0	1	2	3	4	5	6	7	8	9	10
Difficulty doing more than one thing at a time?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10
MOTOR & COORDINATION:											
Having weakness on one side of your body?	0	1	2	3	4	5	6	7	8	9	10
Tremor or shakiness?	0	1	2	3	4	5	6	7	8	9	10
Balance problems?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10

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PHYSICAL:											
Headaches?	0	1	2	3	4	5	6	7	8	9	10
Dizzy spells?	0	1	2	3	4	5	6	7	8	9	10
Sleep Disturbance?	0	1	2	3	4	5	6	7	8	9	10
Loss of Appetite?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10
EMOTIONAL & BEHAVIORAL:											
Sadness or depression?	0	1	2	3	4	5	6	7	8	9	10
Anxiety?	0	1	2	3	4	5	6	7	8	9	10
Frustration/Anger?	0	1	2	3	4	5	6	7	8	9	10
Worry/Stress	0	1	2	3	4	5	6	7	8	9	10
SENSORY:											
Changes or difficulties with vision?	0	1	2	3	4	5	6	7	8	9	10
Changes or difficulties with hearing?	0	1	2	3	4	5	6	7	8	9	10
Changes or difficulties with taste; lost sense of taste?	0	1	2	3	4	5	6	7	8	9	10
Changes in sense of smell; lost sense of smell?	0	1	2	3	4	5	6	7	8	9	10
Changes in sense of touch; numbness or tingling	0	1	2	3	4	5	6	7	8	9	10

ACTIVITIES OF DAILY LIVING:				
Please indicate if you are able to perform the following and, if not, the degree of assistance you need.	NO DIFFICULTY	MINIMAL ASSISTANCE	MODERATE ASSISTANCE	UNABLE TO PERFORM
Bathe Yourself	☐	☐	☐	☐
Maintain Self-Care	☐	☐	☐	☐
Toileting/Bowel/Bladder	☐	☐	☐	☐
Dress/Clothe Yourself	☐	☐	☐	☐
Feed Yourself	☐	☐	☐	☐
Prepare Meals/Cook	☐	☐	☐	☐
Shop for Groceries	☐	☐	☐	☐
Do the Laundry/Clean Clothes	☐	☐	☐	☐
Clean the House/Home	☐	☐	☐	☐
Manage Finances/Pay Bills	☐	☐	☐	☐
Use Telephone (i.e., dial 9-1-1)	☐	☐	☐	☐
Drive	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐

STRESS & STRESSORS:											
Level of stress?	0	1	2	3	4	5	6	7	8	9	10
Level of difficulty managing stress?	0	1	2	3	4	5	6	7	8	9	10
Other (specify):	0	1	2	3	4	5	6	7	8	9	10

Please indicate the areas you experience stress, i.e., financial, relationships, work, etc. _____

_____

How do you cope with stress (i.e., meditation; hiking; drinking, etc.) ? _____

_____

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ALLERGIES:

Please list all FOOD allergies: _____

Please list all DRUG allergies: _____

Please list any OTHER allergies: _____

MEDICATIONS:

	MEDICATION(S)	REASON/NECESSITY	DOSAGE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

MEDICAL HISTORY:

CHILDHOOD:

Date of Birth: _____ Place of Birth: _____

How many siblings do you have? _____ Where are you in the birth order? _____

Please describe any complications associated with your mother's pregnancy with you or with your birth,
(I.e., mother was in an automobile accident, or you were oxygen deprived at birth): _____

_____

DEVELOPMENTAL MILESTONES	EARLY	AVERAGE	LATE	DON'T KNOW
Walking	☐	☐	☐	☐
Language/Talking	☐	☐	☐	☐
Toilet Training	☐	☐	☐	☐
Overall Development	☐	☐	☐	☐
Starting School/Kindergarten	☐	☐	☐	☐

MEDICAL ILLNESSES AS AN CHILD:					
ADD/ADHD	☐	Ear Infections (frequent)	☐	Lung (pulmonary) problems	☐
Allergies	☐	Encephalitis	☐	Measles	☐
Asthma	☐	Epilepsy	☐	Meningitis	☐
Brain Disease or Infection	☐	Fevers (104 or higher)	☐	Oxygen Deprivation	☐
Cancer	☐	Heart Problems	☐	Pneumonia	☐
Cerebral Palsy	☐	Head Injuries	☐	Poisoning	☐
Chicken Pox	☐	Immune System Disease	☐	Rheumatic or Scarlet Fever	☐
Colds	☐	Kidney Problems	☐	Tuberculosis	☐
Diabetes	☐	Loss of Consciousness	☐	Whooping Cough	☐

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MEDICAL ILLNESSES AS AN ADULT:					
ADD/ADHD	☐	Encephalitis	☐	Meningitis	☐
AIDS/HIV	☐	Epilepsy/Seizure Disorder	☐	Multiple Sclerosis	☐
Arteriosclerosis	☐	Exposure to hazardous subs	☐	Parkinson's Disease	☐
Arthritis	☐	Heart Disease	☐	Polio	☐
Asthma	☐	High Cholesterol	☐	Psychiatric Problems	☐
Blood/Immune Disorder	☐	Huntington's Chorea	☐	Radiation (i.e., treatment)	☐
Brain Disease	☐	Hypertension	☐	Sleep Apnea	☐
Brain Cancer	☐	Kidney Disease	☐	Stroke or TIA	☐
Cancer or Chemotherapy	☐	Liver Disease	☐	Syphilis	☐
Dementia or 'Senility'	☐	Lung (pulmonary) Problems	☐	Thyroid Disease	☐
Diabetes	☐	Malnutrition	☐	Venereal Disease	☐

FAMILY MEDICAL HISTORY:

Please list any significant medical condition(s) in your immediate family and who has the condition. This includes any of your biological family members such as your mother, father, brother, sister, aunt, uncle, or grandparents:
Example: Coronary Disease (father), Alzheimer's Disease (maternal aunt), etc.: _____

_____

_____

PSYCHIATRIC HISTORY:

Any psychological/emotional condition(s) as a child (<18 yrs-old)? _____

Have you ever formally been diagnosed with a mental health or psychiatric condition (i.e., bipolar; depression, anxiety)? _____

Are you currently in psychotherapy or under the care of a psychiatrist? Yes ☐ No ☐

If so, how long have you been in treatment? _____

Please describe: _____

_____

FAMILY PSYCHIATRIC HISTORY:

Please list any significant psychiatric condition(s) in your immediate family and who has the condition. This includes any of your biological family members such as your mother, father, brother, sister, aunt, uncle, or grandparents: Example: Schizophrenia (son), Depression (father), and Suicide (paternal uncle) etc.: _____

_____

PSYCHOSOCIAL HISTORY:

Mother:

Highest education your mother achieved: ___ Years ___

Mother's Occupation: _____

Is your mother still alive? _____ Current Age? _____

If deceased, what was cause of death? _____

Age when passed: _____

Father:

Highest education your father achieved: ___ Years ___

Father's occupation: _____

Is your father still alive? _____ Current Age? _____

If deceased, what was cause of death? _____

Age when passed: _____

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Marital History/Status:

Single	☐	Widowed	☐
Single, living with a partner	☐	Separated	☐
Married	☐	Divorced	☐

Number of times married: _____ Number times divorced: _____

Length of time (years) married: _____

Partner's occupation: _____

Partner's health status: _____

Children & Grandchildren:

Do you have any children? Yes ☐ No ☐ How many? _____ Ages: _____

Do you have any grandchildren? Yes ☐ No ☐ How many? _____ Ages: _____

EDUCATION:

What is the highest grade completed or decree you have earned?

☐ Pre-High School (<12 yrs)	☐ University/College (15-16 yrs)
☐ High School Graduate (12 yrs)	☐ Masters Level (18 yrs)
☐ Associate Decree (14 yrs)	☐ Doctorate (20 yrs)
☐ Technical School (14-15 yrs)	☐ Post/Doctoral (>20 yrs)

How would you describe your usual performance in school?

☐ A & B	☐ C & D
☐ B & C	☐ D & F

Was all of your education conducted in English in the United States? Yes ☐ No ☐

If not, please describe: _____

Were you ever held back to repeat a grade? Yes ☐ No ☐

If not, please describe: _____

Were you ever in special education classes? Yes ☐ No ☐

If not, please describe: _____

Were you ever in advanced placement or skipped a grade? Yes ☐ No ☐

If not, please describe: _____

EMPLOYMENT:

What type of work do you currently do? _____

_____

How long: _____

What other types of work have you down? _____

_____

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SUBSTANCE USE:

Please indicate all substances you have tried, age 1st tried and frequency.	NONE	CURENTLY	AGE 1ST TRIED	TRIED ONLY (1-2 X)	MINIMAL 1-2 X / YR	MODERATE 1-4x/MO	FREQUENT 1+X/DY
Alcohol	☐	☐	☐	☐	☐	☐	☐
Amphetamines (uppers, etc.)	☐	☐	☐	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

Have others told you, your substance abuse is a problem? Yes ☐ No ☐

If yes, please describe: _____

Have you been in treatment for your substance abuse? Yes ☐ No ☐

If not, please describe: _____

Are there any family members/relatives with a history of substance abuse? Yes ☐ No ☐

If not, please describe: _____

LEGAL/FORENSIC HISTORY:

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY.	X
Arrest(s)	☐
Incarceration(s)	☐
Legal Case(s)/Legal Action	☐
Workers Compensation Claim(s)	☐
Disability Claim(s)	☐
Other (specify):	☐

If you answered yes to any of the above, briefly explain the situation or circumstances: _____

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.