ADULT INTAKE QUESTIONNAIRE - P

Please fill out this form as completely as possible. The information you provide is confidential and protected by law.

Date: _____

Name: _____ Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Who referred you? _____
_____

What questions do you hope will be answered about your child and your relationship with your child?
_____
_____
_____

MEDICAL HISTORY

Name of primary care physician & clinic name: _____
Date of last physical examination: _____
Purpose of physical examination: _____
_____

☐ **Major Surgery** (attach additional information/list if needed):

Procedure: _____ Procedure: _____
_____ _____
Age: _____ Age: _____
☐ No complications ☐ No complications
Complications: _____ Complications: _____
_____ _____

☐ **Medical Hospitalization** (attach additional information/list if needed):

Cause: _____ Cause: _____
_____ _____
_____ _____
Dates/Age: _____ Dates/Age: _____

☐ **Medical Diagnoses:**

1.	3.	5.
2.	4.	6.

As a child did you ever experience the following? If yes, please elaborate.

☐ High fever requiring hospitalization or treatment: _____
☐ Unexplained fever or spike of temperature: _____
☐ Head injury: _____
☐ Concussion: _____
☐ Loss of consciousness: _____
☐ Seizures Type: ☐ Partial ☐ Partial complex ☐ Generalized
Beginning at what age: _____ Frequency: _____
☐ Tics – please describe: _____
☐ Thyroid or endocrine problems
☐ Chronic ear/sinus infections Were tubes required? ☐ No ☐ Yes, at what age(s): _____
☐ Chronic allergies ☐ Diabetes/blood sugar problems ☐ Meningitis, encephalitis
☐ Bronchitis, pneumonia ☐ Upper respiratory problems/asthma
☐ Other congenital conditions: _____

Please list currently prescribed medications:

	Medication	Dose	Frequency	Prescribing Physician
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Current Medical Conditions/Illnesses

Hearing: ☐ No problems ☐ Conductive impairment ☐ Sensori-neural impairment ☐ Hearing devices

Vision: ☐ No problem ☐ Nearsighted ☐ Farsighted ☐ Glasses ☐ Contacts ☐ Blind ☐ Other: _____

Current Sleep

☐ Duration in hours: _____ ☐ Requires naps ☐ Difficulty falling asleep ☐ Staying asleep

☐ Nightmares ☐ Frequency: _____ per week

Appetite

☐ No problems ☐ Obsessed with food – since: _____ ☐ Increased/decreased appetite—since: _____

☐ Weight gain/loss ☐ Amount in pounds: _____ Since: _____

Have you been diagnosed previously with any type of developmental diagnosis? (Please circle applicable diagnosis.)

ADHD/ADD

When was the diagnosis made? _____

Autistic spectrum disorder (autism, Asperger's syndrome, PDD.NOS)

When was the diagnosis made? _____

Cognitive impairment / mild / moderate / severe mental retardation

When was the diagnosis made? _____

Receptive / expressive / mixed speech delay

When was the diagnosis made? _____

Learning Disability

When was the diagnosis made? _____

Other / psychiatric diagnoses

What was/were the diagnosis(es)? _____

PSYCHIATRIC HISTORY

☐ **Psychiatric hospitalization** Where: _____

Cause:_____ Cause: _____

_____ _____

Dates/Age: _____ Dates/Age: _____

Ever treated by a mental health professional(s)? ☐ Yes ☐ No

	Name of Professional	Time Frame/Dates of Treatment
Psychologist(s):	_____	_____
Psychiatrist(s):	_____	_____
Neurologist(s):	_____	_____
Therapist(s):	_____	_____

Current mental health professional(s)? ☐ Yes ☐ No

	Name of Professional	Time Frame/Dates of Treatment
Psychologist(s):	_____	_____
Psychiatrist(s):	_____	_____
Neurologist(s):	_____	_____
Therapist(s):	_____	_____

Are you currently experiencing any of the following?

Nearly Daily	Sometimes	Not Really	
_____	_____	_____	Trouble remembering things
_____	_____	_____	Spells of sudden fear that did not make sense
_____	_____	_____	Trouble doing your job or schoolwork
_____	_____	_____	Thoughts of dying
_____	_____	_____	Someone thinks you drink too much
_____	_____	_____	Being in too many arguments
_____	_____	_____	Avoiding things/places most people do not avoid
_____	_____	_____	Being in trouble
_____	_____	_____	Feeling keyed up or on the edge
_____	_____	_____	Having peculiar thoughts
_____	_____	_____	Difficulties with sexual matters
_____	_____	_____	Increased stress in your life
_____	_____	_____	Worry
_____	_____	_____	Feelings of guilt
_____	_____	_____	Sad mood
_____	_____	_____	Irritability, easily annoyed
_____	_____	_____	Rage, sudden out bursts of anger
_____	_____	_____	Poor concentration
_____	_____	_____	Sleep problems
_____	_____	_____	Low energy
_____	_____	_____	Headaches
_____	_____	_____	Shortness of breath, chest pains
_____	_____	_____	Dizziness, numbness
_____	_____	_____	Trembling
_____	_____	_____	Pains
_____	_____	_____	Loss of appetite
_____	_____	_____	Overeating
_____	_____	_____	Other: _____

SUBSTANCE ABUSE

Please indicate any substance used currently or in the past and effects:

Current	Past		Effects following substance use		
☐	☐	Alcohol	☐ Blackouts	☐ Sweats	☐ Rage
☐	☐	Marijuana	☐ Cravings	☐ Pass out	☐ Depressed mood
☐	☐	Cocaine	☐ Nausea	☐ Paranoia	☐ Hyper
☐	☐	Heroin	☐ Dizziness	☐ Lethargy	☐ Extreme thirst
☐	☐	Ecstasy	☐ Trembling	☐ Slurred speech	☐ Unstable gait
☐	☐	Huffing (gas, aerosol, etc.)			
☐	☐	Other: _____			

Please indicate the word(s) that best describe your alcohol or drug use:

☐ Experimental ☐ Recreational ☐ Abusive ☐ Dependent ☐ Minimal ☐ Destructive

Have you ever attended a substance abuse treatment program? ☐ No ☐ Yes, dates: _____

Where: _____

FAMILY OF ORIGIN Please list all living and deceased.

	Name	Age	Occupation/School	Lives with child
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Stepsiblings				

How would you describe your relationship with your parent and siblings while growing up?

_____

_____

Now? _____

_____

If parents divorced, describe child placement: _____

_____

_____

FAMILY

Current Living Situation/Marital Status

☐ Never married, living in:	☐ own home	☐ rented apartment	☐ other: _____
☐ Legally married, living in:	☐ own home	☐ rented apartment	☐ other: _____
☐ Unmarried—committed relationship, living in:	☐ own home	☐ rented apartment	☐ other: _____
☐ Divorced, living in:	☐ own home	☐ rented apartment	☐ other: _____
☐ Separated, living in:	☐ own home	☐ rented apartment	☐ other: _____

MARRIAGE AND FAMILY

Date of marriage: _____

Date of divorce: _____

Date(s) of previous marriage(s): _____

Date(s) of previous divorce(s): _____

Name of current spouse/significant other:

_____

Age: _____ DOB: _____ Dates of previous marriage: _____ Divorce: _____

Name of employer: _____ Job title: _____

Names of your children:

Biological, Adopted, or Step	DOB	School Level/Occupation

How would you describe your relationship with your spouse/significant other?_____

_____

If not living with child's other parent, please describe your relationship with other parent?_____

_____

How would you describe your relationship with your children? _____

_____

Please describe how you parent your child: strengths, weaknesses, parenting beliefs, discipline, activities, affirmations.

_____

_____

_____

Persons living in the home:

Name	Age	Nature of Relationship to You	Quality of Relationship
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor

Paternal (biological father's) Family History

☐ ADHD, ADD, impulsivity
☐ Autistic spectrum disorders
☐ Learning disorder, learning problems
☐ Depression
☐ Anxiety, panic attacks
☐ Bipolar disorder ("manic-depression")
☐ Alcohol/drug abuse
☐ Schizophrenia or other psychotic/delusional disorders
☐ Cardiopulmonary difficulties
☐ Specific genetic problem: _____
☐ Specific neurological disorder: _____
☐ Other: _____

Maternal (biological mother's) Family History

☐ ADHD, ADD, impulsivity
☐ Autistic spectrum disorders
☐ Learning disorder, learning problems
☐ Depression
☐ Anxiety, panic attacks
☐ Bipolar disorder ("manic-depression")
☐ Alcohol/drug abuse
☐ Schizophrenia or other psychotic/delusional disorders
☐ Cardiopulmonary difficulties
☐ Specific genetic problem: _____
☐ Specific neurological disorder: _____
☐ Other: _____

Significant Trauma (include age at time of incident, nature of trauma, and any legal details)

☐ Injured in an accident: _____
☐ Physical abuse (☐ victim ☐ perpetrator): _____
☐ Sexual assault/abuse (☐ victim ☐ perpetrator): _____
☐ Emotional abuse (☐ victim ☐ perpetrator): _____
☐ Neglect: _____

LEGAL

Please detail any contacts (including dates and outcomes) you have had with the courts, police, etc.:

_____

_____

EMPLOYMENT
Have you ever been employed? ☐ Yes ☐ No
Were you ever fired? ☐ No ☐ Yes – details: _____
Current job status: ☐ Full-time ☐ Part-time ☐ Disabled ☐ Laid off ☐ Retired ☐ Other: _____

Jobs held:

Employer	Dates	Job Title	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Financial status: ☐ Stable ☐ Unstable: _____

Military Service: ☐ No ☐ Yes Dates: _____ Discharge: _____
☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard
☐ Reserves: _____ ☐ National Guard: _____

PERSONAL INFORMATION
What are your greatest strengths/attributes? _____
_____

Hobbies/Interests

	Recent change in frequency?		
_____	☐ No change	☐ Decreased	☐ Increased
_____	☐ No change	☐ Decreased	☐ Increased
_____	☐ No change	☐ Decreased	☐ Increased

ACADEMIC
Started school at age: _____ Highest grade completed: _____ Age: _____

Did you utilize Special Education support services? ☐ No ☐ Yes
Please specify below all classifications that have been used, and *circle any current classification*.
☐ Cognitively impaired ☐ Emotionally impaired ☐ Hearing impaired ☐ Visually impaired
☐ Other health impairment ☐ Severe multiple impairment ☐ Speech and language impairment
☐ Learning disabled: _____
Academic Performance:
☐ Consistently A's, B's ☐ Consistently B's, C's
☐ Consistently C's, D's ☐ Consistently C's, D's
☐ Consistently D's, F's ☐ Consistently F's
☐ Dropped out of school (at age: _____, grade: _____)
☐ Graduated from high school ☐ Obtained GED ☐ Regular diploma ☐ Special education certificate
☐ College name, degree, and major: _____
☐ Advanced University degrees: _____

As a child were you ever:
☐ Held back – What grades? _____
☐ Suspended – For what and for how long? _____
☐ Expelled – From what grade and why? _____
☐ Home schooled – When and why? _____

Additional information you would like to let the clinician know:
_____
_____
_____
_____

Completed by: _____ **Date:** _____