

ADULT INTAKE QUESTIONNAIRE

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

Date: _____

Demographic Information

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

Who referred you? _____

What questions do you hope will be answered? _____

What concerns bring you here?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Irresponsible | <input type="checkbox"/> Employment | <input type="checkbox"/> Marriage/family | <input type="checkbox"/> Mood problems |
| <input type="checkbox"/> Problems with mobility | <input type="checkbox"/> Physical pain/injury | <input type="checkbox"/> Inadequate energy | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Problems with speech | <input type="checkbox"/> Social relationships | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Recognition of danger | <input type="checkbox"/> Sleep problem | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Money management | <input type="checkbox"/> Appetite problem | <input type="checkbox"/> Cognitive problems | |

DEVELOPMENTAL HISTORY

Mother's age at time of your birth: _____ Father's age at time of your birth: _____

What were the complications or concerns during your pregnancy for your mother? None

(If any of the following occurred, please elaborate on condition/treatment.)

- | | | | | | |
|---|--|--|--|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Preeclampsia | <input type="checkbox"/> Placenta previa | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Physical trauma | <input type="checkbox"/> Other: _____ | | |

Length of Pregnancy

- Full term Premature – born at how many weeks? _____

Was labor induced? No Yes, please describe the reason: _____

Mode of delivery: Vaginal Cesarean Emergency Cesarean

Were there any concerns or complications during/immediately following your delivery?

- | | |
|---|---|
| <input type="checkbox"/> Baby's heart rate dropped | <input type="checkbox"/> Cord wrapped around neck/nuchal cord |
| <input type="checkbox"/> Born "blue" | <input type="checkbox"/> Breech |
| <input type="checkbox"/> Low Apgar scores | <input type="checkbox"/> Significant jaundice (bilirubin) |
| <input type="checkbox"/> Treatment in the NICU – details: _____ | |

Temperament as an infant: Easy Withdrawn Difficult Other: _____

Bonding: Cuddly Withdrawn Clingy Other: _____

Activity level as an infant: Average On-the-go Destructive Lethargic Accident prone

Apprehension with strangers: Mild Moderate Severe None

Emotionally oversensitive/over-reactive as an infant: No Yes

Does this continue to be a problem? No Yes

Developmental milestones (check all that apply if you know):

12 Months:

- Pulls to stand and may take a few steps alone
- Says 2-4 words, imitates vocalizations
- Waves "bye-bye"
- Drinks from cup
- Looks for dropped or hidden objects
- Feeds self

18 Months:

- Walks backward
- Uses two-word phrases
- Follows simple directions
- Throws ball
- Uses a spoon and cup
- Points to some body parts
- Scribbles
- Shows affection, kisses
- Pulls a toy along the ground

24 Months:

- Goes up and down stairs one step at a time
- Stacks five blocks
- Follows two-step commands
- Kicks ball
- Uses at least 20 words, two-word phrases
- Imitates adults

5 Years:

- Dresses self without help
- Can count on fingers
- Recognizes most letters and print some
- Learns address/phone number
- Copies basic shapes

11-21 Years:

- Sexual development
- Peer relationships
- Social/emotional interaction
- Worries about grades

MEDICAL HISTORY

Date of last physical examination: _____

Purpose of physical examination: _____

Name of primary care physician & clinic name: _____

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:

	<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Prescribing Physician</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Past medications that have produced a negative reaction/ineffective medications:

	<u>Medication</u>	<u>Reason for Discontinuation</u>
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 Midnight awakening Early awakening

Difficulty falling asleep Other: _____

Nightmares Frequency: _____ per week Content: _____

Appetite

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

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

PSYCHIATRIC HISTORY

Psychiatric hospitalization

Where: _____

Cause: _____

Cause: _____

Dates/Age: _____

Dates/Age: _____

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)? _____

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

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

Current mental health professional(s)? Yes No

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

Are you currently experiencing any of the following?

<u>Nearly Daily</u>	<u>Sometimes</u>	<u>Not Really</u>	
_____	_____	_____	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 to 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
_____	_____	_____	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:

<u>Current</u>	<u>Past</u>							
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	Rage
<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	Cravings	<input type="checkbox"/>	Pass out	<input type="checkbox"/>	Depressed mood
<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Paranoia	<input type="checkbox"/>	Hyper
<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Lethargy	<input type="checkbox"/>	Extreme thirst
<input type="checkbox"/>	<input type="checkbox"/>	Ecstasy	<input type="checkbox"/>	Trembling	<input type="checkbox"/>	Slurred speech	<input type="checkbox"/>	Unstable gait
<input type="checkbox"/>	<input type="checkbox"/>	Huffing (gas, aerosol, etc.)						
<input type="checkbox"/>	<input type="checkbox"/>	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.

	<u>Name</u>	<u>Age</u>	<u>Occupation/School</u>	<u>Lives with child</u>
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

- | | | | |
|---|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Never married, living in: | <input type="checkbox"/> own home | <input type="checkbox"/> rented apartment | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> Legally married, living in: | <input type="checkbox"/> own home | <input type="checkbox"/> rented apartment | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> Unmarried—committed relationship, living in: | <input type="checkbox"/> own home | <input type="checkbox"/> rented apartment | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> Divorced, living in: | <input type="checkbox"/> own home | <input type="checkbox"/> rented apartment | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> Separated, living in: | <input type="checkbox"/> own home | <input type="checkbox"/> rented apartment | <input type="checkbox"/> other: _____ |

MARRIAGE AND FAMILY

Date of marriage: _____
 Date of divorce: _____
 Date(s) of previous marriage(s): _____
 Date(s) of previous divorce(s): _____
 Name of spouse/significant other: _____
 Age: _____ DOB: _____ Dates of previous marriage: _____ Divorce: _____
 Name of employer: _____ Job title: _____

Names of your children:

<u>Biological, Step, or Adopted</u>	<u>DOB</u>	<u>School Level/Occupation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

How would you describe your relationship with your children? _____

Persons living in the home:

<u>Name</u>	<u>Age</u>	<u>Nature of Relationship to You</u>	<u>Quality of Relationship</u>		
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

Other important persons in your life:

<u>Name</u>	<u>Age</u>	<u>Nature of Relationship to You</u>	<u>Quality of Relationship</u>		
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> 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:

<u>Employer</u>	<u>Dates</u>	<u>Job Title</u>	<u>Reason for Leaving</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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
 Dropped out of school (at age: _____, grade: _____)
 Graduated from high school Obtained GED Regular diploma Special education certificate
 College name, degree, and major: _____

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: _____