

ADULT ASSESSMENT QUESTIONNAIRE

To help fully evaluate your concerns, please fill out the following intake form and questionnaire to the best of your ability. A lot of information is requested and you may not remember or have access to all of it, but please be as thorough as possible.

PATIENT IDENTIFICATION:

Name _____ Age _____ Gender _____
Birth Date _____ Marital Status _____
Address _____
City _____ State _____ Zip _____
Home Phone ___ / ___ - _____ Okay to call/leave message? Y / N
Work Phone ___ / ___ - _____ Okay to call/leave message? Y / N
Cell Phone ___ / ___ - _____ Okay to call/leave message? Y / N
E-Mail _____

REFERRAL SOURCE:

Name _____ Phone ___ / ___ - _____ Fax ___ / ___ - _____
Address _____
May I release information to the referral source when it is appropriate? Yes ___ No ___

MAIN PURPOSE FOR THE CONSULTATION (please give a summary of the main problem)

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? (What are your goals for this visit?)

PLEASE LIST YOUR HISTORY OF PRIOR ATTEMPTS TO CORRECT YOUR PROBLEM/ PRIOR PSYCHIATRIC HISTORY.

WHAT MAKES THE PROBLEM WORSE?

WHAT MAKES THE PROBLEM BETTER?

WHAT HAS CHANGED IN YOUR LIFE AS A RESULT OF YOUR PRIMARY CONCERN?

MEDICAL HISTORY:

Current medical problems and/or medications? Y / N

Current Supplements/vitamins/herbs? Y / N

Past medical problems/medications? Y / N

Other doctors/clinics seen regularly? Y / N

Any history of head trauma? Y / N

Any history of seizures or seizure-like activity? Y / N

Prior hospitalizations? Y / N

Prior abnormal lab tests/values? Y / N

Allergies/ drug intolerance? Y / N

CURRENT LIFE STRESSES: (include anything that is currently stressful for you, such as relationships, job, school, finances, children, etc.) _____

SLEEP BEHAVIOR:

	None	Mild	Moderate	Extreme
Difficulty falling asleep				
Difficulty staying asleep				
Early waking				
Sleepwalking				
Nightmares				
Excessive daytime sleepiness				

SCHOOL HISTORY:

Last grade completed _____ Last school attended _____

Average grades received _____ Graduate Y or N Specific learning disabilities _____

Favorite classes _____
Why? _____

Least favorite classes _____
Why? _____

Any behavior problems in school? _____

What have teachers said about your learning and behavior in school? (Please send copies of any report cards, state testing, psychological tests that have been done in the past.) _____

EMPLOYMENT HISTORY: (summarize the jobs you have held; most favorite, least favorite)

Longest job held (how long held) _____ Shortest job held (how long held) _____
Any work-related problems? _____

What have your employers and supervisors said about your performance? _____

MILITARY HISTORY:

Branch: _____ Length of service: _____ Type of separation: _____

LEGAL PROBLEMS/DIFFICULTY WITH THE LAW:

ALCOHOL AND DRUG HISTORY: (Please list the age you started, types of substances used through the years and any current usage)

Did you ever experience withdrawal symptoms from alcohol or drugs?	Y / N
Has anyone ever told you they thought you had a problem with drugs or alcohol?	Y / N
Have you felt guilty about your drug or alcohol use?	Y / N
Have you felt annoyed when someone talked to you about your use of drugs/alcohol?	Y / N
Have you ever used alcohol or drugs first thing in the morning?	Y / N
Caffeine use per day (coffee, tea, sodas, chocolate)?	Y / N
Nicotine use per day, past and present (cigarettes, cigars, chewing tobacco)?	Y / N

SEXUAL HISTORY:

Heterosexual / Bisexual / Gay / Lesbian _____ Age of first sexual experience: _____

Number of sex partners: _____ Sexually transmitted diseases: _____

History of abortion: _____

History of sexual molestation, abuse or rape (if so, please explain): _____

Current sexual problems? _____

FAMILY HISTORY:

Family structure (Who lives in your current household? Please give relationship to each)

Current marital or relationship satisfaction:

Significant events (include marriages, separations, divorces, deaths, traumatic events)

History of past marriages:

NATURAL MOTHER’S HISTORY:

Age: _____ Living / Deceased Employed / Unemployed / Retired
Current employment: _____ Years employed: _____
Highest grade completed: _____
Learning Problems _____ Behavioral Problems _____
Marriages _____
Medical Problems _____

NATURAL FATHER’S HISTORY:

Age: _____ Living / Deceased Employed / Unemployed / Retired
Current employment: _____ Years employed: _____
Highest grade completed: _____
Learning Problems _____ Behavioral Problems _____
Marriages _____
Medical Problems _____

SIBLINGS: (Names, ages, problems, strengths, relations with patient)

CHILDREN: (Names, ages, problems, strengths, relations with patient)

FAMILY PSYCHIATRIC HISTORY:

	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Attention Deficit Disorder (ADD/ADHD)					
Bipolar Disorder					
Alcohol/Drug Abuse					
Mental Retardation					
Depression					

Anxiety (Panic Disorder, Etc.)					
Learning Disability					
Schizophrenia/Psychosis					
Other					

CULTURAL/ETHNIC BACKGROUND:

DESCRIBE YOUR RELATIONSHIP WITH FRIENDS:

DESCRIBE YOURSELF/ YOUR STRENGTHS:

RISK ASSESSMENT:

	Currently	< 6 mos	> 6 mos	Never
Recurrent thoughts about death				
Believing that others would be “better off” if you were dead				
Feeling hopeless about your life and future				
A family member or close friend has completed suicide				
Self-harming behaviors without intent to die				
Recurrent thoughts about killing yourself				
Thinking about a plan to kill yourself				
Active preparation to kill yourself				
Attempting to kill yourself				
Recurrent thoughts about killing others				
Thinking about a plan to kill someone else				
Active preparation to kill someone else				

GENERAL SYMPTOM CHECKLIST:

Please rate yourself on each of the symptoms below using the following scale.

0 1 2 3 4 N/A
Never Rarely Occasionally Frequently Very Frequently Not applicable

- _____ 1. Depressed or sad mood
- _____ 2. Decreased interest in things that are usually fun, including sex
- _____ 3. Significant weight gain or loss, or marked appetite changes
- _____ 4. Recurrent thoughts of death or suicide
- _____ 5. Sleep changes, lack of sleep or marked increase in sleep
- _____ 6. Physically agitated OR slowed down

- _____ 7. Low energy or feelings of tiredness
 _____ 8. Feelings of worthlessness, helplessness, hopelessness, or guilt
 _____ 9. Decreased concentration or memory
 _____ 10. Periods of an elevated, high or irritable mood
 _____ 11. Periods of a very high self-esteem, or grandiose thinking
 _____ 12. Periods of decreased need for sleep without feeling tired
 _____ 13. More talkative than usual or feel pressure to keep talking
 _____ 14. Racing thoughts; frequent jumps from one subject to another
 _____ 15. Easily distracted by irrelevant things
 _____ 16. Marked increases in activity level
 _____ 17. Excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures)
 _____ 18. Panic attacks, which are period of intense, unexpected fear or emotional discomfort (list number per month _____)
 _____ 19. Periods of trouble breathing or feeling smothered
 _____ 20. Periods of feeling dizzy, faint, or unsteady on your feet
 _____ 21. Periods of heart pounding or rapid heart rate
 _____ 22. Periods of trembling or shaking
 _____ 23. Periods of sweating
 _____ 24. Periods of choking
 _____ 25. Periods of nausea or abdominal upset
 _____ 26. Feeling of a situation "not being real"
 _____ 27. Numbness or tingling sensation
 _____ 28. Hot or cold flashes
 _____ 29. Periods of chest pain or discomfort
 _____ 30. Fear of dying
 _____ 31. Fear of going crazy or doing something uncontrolled
 _____ 32. Avoiding everyday places for fear of having a panic attack, or need to go with other people in order to feel comfortable
 _____ 33. Excessive fear of being judged by others, which causes you to avoid or get anxious in situations
 _____ 34. Persistent, excessive phobias (heights, closed spaces, specific animals, etc.) Please list _____
 _____ 35. Recurrent, bothersome thoughts, ideas, images, which you try to ignore
 _____ 36. Trouble getting "stuck" on certain thoughts, or having the same thought over and over
 _____ 37. Excessive or senseless worrying
 _____ 38. Others complain that you worry too much or get "stuck" on the same thoughts
 _____ 39. Compulsive behaviors that you must do over and over or else you feel anxious (i.e., hand washing, checking locks), or compulsive spelling or counting
 _____ 40. Needing to have things done a certain way or you become upset
 _____ 41. Others complain that you do the same thing over and over to an excessive degree (cleaning, checking)
 _____ 42. Recurrent and upsetting thoughts of a past traumatic event (molestation, accident, fire, etc)
 _____ 43. Recurrent distressing dreams of a past upsetting event
 _____ 44. A sense of reliving a past upsetting event
 _____ 45. A sense of panic or fear to events that resemble an upsetting past event
 _____ 46. You spend effort avoiding thoughts or feelings associated with a past trauma
 _____ 47. Persistent avoidance of activities/situations which cause remembrance of upsetting events
 _____ 48. Inability to recall an important aspect of a past upsetting event

- ___ 49. Marked decreased interest in important activities
- ___ 50. Feeling detached or distant from others
- ___ 51. Feeling numb or restricted in your feelings
- ___ 52. Feeling that your future is shortened
- ___ 53. Quick startle
- ___ 54. Feel like you are always watching for bad things to happen
- ___ 55. Marked physical response to events that remind you of a past upsetting event (i.e., sweating when getting in a car long after you have been in an accident)
- ___ 56. Marked irritability or angry outbursts
- ___ 57. Unrealistic or excessive worry in at least a couple of areas in your life
- ___ 58. Trembling, twitching or feeling shaky
- ___ 59. Muscle tension, aches or soreness
- ___ 60. Easily fatigued
- ___ 61. Feelings of restlessness
- ___ 62. Shortness of breath or feeling smothered
- ___ 63. Heart pounding or racing
- ___ 64. Sweating or cold clammy hands
- ___ 65. Dry mouth
- ___ 66. Dizziness or lightheadedness
- ___ 67. Nausea, diarrhea, or other abdominal distress
- ___ 68. Hot or cold flashes
- ___ 69. Frequent urination
- ___ 70. Trouble swallowing or “lump in throat”
- ___ 71. Feeling keyed up or on edge
- ___ 72. Quick startle response or jumpy feeling
- ___ 73. Difficulty concentrating or “mind going blank”
- ___ 74. Trouble falling asleep or staying asleep
- ___ 75. Irritability
- ___ 76. Trouble sustaining attention or being easily distracted
- ___ 77. Difficulty completing projects
- ___ 78. Feeling overwhelmed with the tasks of everyday life
- ___ 79. Trouble maintaining an organized work area or living area
- ___ 80. Inconsistent work performance
- ___ 81. Lack of attention to detail
- ___ 82. Make decisions impulsively
- ___ 83. Difficulty delaying what you want, having to have your needs met immediately
- ___ 84. Restless or fidgety
- ___ 85. Make comments to others without considering their impact
- ___ 86. Impatient, easily frustrated
- ___ 87. Frequent traffic violations or frequent near accidents
- ___ 88. Refusal to maintain body weight above a level most people consider healthy
- ___ 89. Intense fear of gaining weight or becoming fat even though underweight
- ___ 90. Feelings of being fat, even though you are underweight
- ___ 91. Recurrent episodes of binge eating
- ___ 92. Feeling of lack of control over eating behavior
- ___ 93. Persistent over concern with body shape or weight
- ___ 94. Engage in regular activities to end binges such as self-induced vomiting, laxatives, diuretics, dieting or strenuous exercise

- ___ ___ 95. Involuntary movements (tics) or vocal tics
- ___ ___ 96. Delusional or bizarre thoughts (that you know others would think are false)
- ___ ___ 97. Seeing objects, shadows or movements that are not real
- ___ ___ 98. Hearing voices or sounds that are not real
- ___ ___ 99. Periods of time where your thoughts or speech were disjointed or did not make sense to you or others
- ___ ___ 100. Social isolation or withdrawal
- ___ ___ 101. Severely impaired ability to function at home or work or socially
- ___ ___ 102. Peculiar behaviors
- ___ ___ 103. Lack of personal hygiene or grooming
- ___ ___ 104. Marked lack of initiative
- ___ ___ 105. Inappropriate mood for the situation (laughing at sad events)
- ___ ___ 106. Frequent feeling that someone or something is out to hurt you or discredit you
- ___ ___ 107. Do others complain that you snore loudly?
- ___ ___ 108. Have others said you stop breathing when you sleep?
- ___ ___ 109. Do you feel fatigued or tired during the day?
- ___ ___ 110. Do you often feel cold when others feel fine or warm?
- ___ ___ 111. Do you often feel warm when others feel fine or cool?
- ___ ___ 112. Do you have problems with brittle or dry hair?
- ___ ___ 113. Do you have problems with dry skin?
- ___ ___ 114. Do you have problems with sweating?

LEARNING DISABILITY SCREENING QUESTIONNAIRE (Please complete only if you are being assessed for ADHD/ADD):

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

READING

- ___ 1. I am a poor reader
- ___ 2. I do not like reading
- ___ 3. I make mistakes when reading, like skipping words or lines
- ___ 4. I read the same line twice
- ___ 5. I have problems remembering what I read, even though I have read the words
- ___ 6. I reverse letters when I read (such as b/d, p/q)
- ___ 7. I switch letters in words (such as saw and was)
- ___ 8. My eyes hurt or water when I read
- ___ 9. Words tend to blur when I read
- ___ 10. Words tend to move around the page when I read
- ___ 11. When reading I have difficulty understanding the main idea or identifying important details.

WRITING

- ___ 1. I have “messy” handwriting
- ___ 2. My work tends to be messy
- ___ 3. I prefer to print rather than write in cursive
- ___ 4. My letters run into each other, or there is no space between words
- ___ 5. I have trouble staying within the lines

- ___ 6. I have trouble with grammar and/or punctuation
- ___ 7. I am a poor speller
- ___ 8. I have trouble copying off the board or from a page in a book
- ___ 9. I have trouble getting thoughts from my brain to the paper
- ___ 10. I can tell a story but cannot write it

BODY AWARENESS/SPATIAL RELATIONSHIPS

- ___ 1. I have trouble knowing my left from my right
- ___ 2. I have trouble keeping things within columns or coloring within lines
- ___ 3. I tend to be clumsy, uncoordinated
- ___ 4. I have difficulty with eye/hand coordination
- ___ 5. I have difficulty with concepts, such as up, down, over or under
- ___ 6. I tend to bump into things when walking

ORAL EXPRESSIVE LANGUAGE

- ___ 1. I have difficulty expressing myself in words
- ___ 2. I have trouble finding the right words to say in conversations
- ___ 3. I have trouble getting to the point in a conversation, talking around the subject

RECEPTIVE LANGUAGE

- ___ 1. I have trouble keeping up or understanding what is be said in conversations
- ___ 2. I tend to misunderstand people and give the wrong answer in conversations
- ___ 3. I have trouble understanding directions people give me
- ___ 4. I have trouble telling the direction sound is coming from
- ___ 5. I have trouble filtering out background noise

MATH

- ___ 1. I am poor at math skills for my age (add, subtract, multiple, divide)
- ___ 2. I make careless mistakes in math
- ___ 3. I tend to switch numbers around
- ___ 4. I have trouble with word problems

SEQUENCING

- ___ 1. I have trouble getting everything in the right order when I speak
- ___ 2. I have trouble telling time
- ___ 3. I have trouble saying the alphabet in order
- ___ 4. I have trouble saying the months of the year in order

ABSTRACTION

- ___ 1. I have trouble understanding jokes people tell me
- ___ 2. I tend to take things too literally

ORGANIZATION

- ___ 1. My notebook/paperwork is messy or disorganized
- ___ 2. My room is messy
- ___ 3. I tend to shove everything into my backpack, desk, or drawer
- ___ 4. I have multiple piles around my room
- ___ 5. I have trouble planning my time

6. I am frequently late or in a hurry
 7. I often do not write down assignments or tasks and end up forgetting

MEMORY

1. I have trouble with my memory
 2. I remember things from long ago but not recent events
 3. It is hard for me to memorize things for school or work
 4. I know something one day but do not remember it the next
 5. I forget what I am going to say right in the middle of saying it
 6. I have trouble following directions that have more than one or two steps

SOCIAL SKILLS

1. I have few or no friends
 2. I have trouble reading body language or facial expressions of others
 3. My feelings are often/easily hurt
 4. I tend to get into trouble with friends, teachers, parents or bosses
 5. I feel uncomfortable around people I do not know well
 6. I am teased by others
 7. Friends do not call and ask me to do things with them
 8. I do not get together with others outside of school or work

YOUR PRENATAL AND BIRTH EVENTS:

Mother's age at delivery: _____ Father's age at delivery: _____
 Any labor or birth complications: _____
 Delivered: Premature / On time / Late Evidence of fetal distress: Y / N Birth weight: _____

Are you aware of any problems you have processing sensory information (e.g., visual, auditory, touch, taste, smell)? If yes, please explain: _____

Are you "hypersensitive" to, or does it cause you undue stress/anxiety, when you encounter:
 Light / Touch / Sudden movement / High frequency noises / Excessive noise / Excess of visual stimuli
 Certain smells / Certain foods/tastes

Did you "nestle?" Y / N

Did you prefer separate space to being held? Y / N

Did you prefer to be tightly wrapped or "swaddled"? Y / N

Were your cries soothed when: Fed? Y / N Held? Y / N Changed? Y / N
 Bathed? Y / N Rocked? Y / N

Were you breast fed? Y / N

Were there feeding problems? Y / N (If yes, please describe: _____)

Did you sleep in a separate crib? Y / N Was the crib in the same room with your mother? Y / N

What was your general temperament during the early years? (Please check/circle)

- Easy Adaptable Withdrawn Colicky
 Slow to adapt Difficult Intense

Did you attach to the primary caretaker? Y / N

Who was the primary caretaker? _____

Would you consider the early relationship/attachment between you and your mother?

Strong Moderate Weak

How would you describe your early sleeping patterns?

Regular Irregular Unpredictable

How would you describe your early feeding patterns?

Regular Irregular Unpredictable

What was your early general activity level?

Hyperactive Active Low energy Lethargic

In general, were you:

Easy to care for Difficult to care for

How did you respond to changes in routine or to transitions?

Easy/Adaptable Withdrawn Difficult Crying/Screaming

Did toilet training present any difficulties? Y / N (If yes, please describe: _____)