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## Adult Questionnaire

The following questions are asked so that we can better understand you. This type of information is very helpful in making an accurate diagnosis and providing recommendations. Please read the questions carefully and answer as fully as possible. We will have the opportunity to discuss these questions in detail at the time of your appointment. Thank you.

PLEASE PRINT

DATE \_\_\_\_\_ NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SSN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

May I have your permission to discuss your case with them?  Yes  No

What are your concerns? What do you feel are your difficulties/problems are at this time?

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What strategies have you tried to help? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What questions do you have that you hope this evaluation will answer? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been previously evaluated for a similar problem?  
YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please explain (**Please bring a copy of all reports to the evaluation**):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What treatment, if any, have you received for the above problems? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you see yourself as being forgetful or as having problems with attention and concentration? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there particular kinds of information that you have difficulty processing? (e.g., reading maps, comprehending what you read, etc.) YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do any other family members (i.e., mother, father, brother, sister, aunt, uncle, etc.) suffer from a similar problem, or some type of psychological, emotional, learning problem, and/or nervous disorder, etc.? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please explain:

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**PLEASE LIST EVERYONE WHO LIVES IN YOUR HOME:**

<u>NAME</u>	<u>AGE</u>	<u>BIRTHDATE</u>	<u>RELATIONSHIP TO YOU</u>

**MEDICAL HISTORY**

Have you undergone any type of surgery? YES \_\_\_ NO \_\_\_ If yes, what type of operation did you have, how old were you, how long were you hospitalized, or was the surgery performed on an outpatient basis? \_\_\_

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Have you suffered any type of head injuries? YES \_\_\_ NO \_\_\_ If yes, please indicate your age, how you were injured and whether or not consciousness was lost at the time of the incident, and if so, for how long:

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Have you ever experienced convulsions? YES \_\_\_ NO \_\_\_ If yes, please indicate the nature of the convulsions and whether or not these occurred with high fevers; please indicate your age at the time of the convulsions: \_\_\_\_\_

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Have you experienced persistent high fevers? YES \_\_\_ NO \_\_\_ If yes, please explain: \_\_\_\_\_

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Were you ever in a coma? YES \_\_\_ NO \_\_\_ If yes, please explain: \_\_\_\_\_

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Do you suffer from allergies? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please explain type of allergic reaction and the treatment you are receiving, if any: \_\_\_\_\_

Please indicate if you or any member of your family has had any of the following medical problems.

<input checked="" type="checkbox"/>	<u>Medical Condition</u>	<input checked="" type="checkbox"/>	<u>Medical Condition</u>
<input type="checkbox"/>	Attention Deficit/Hyperactivity Disorder	<input type="checkbox"/>	Hydrocephalus
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Language Delay
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Learning Disability
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Lead poisoning/exposure
<input type="checkbox"/>	Autism	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	Dementia (Alzheimer's or other)	<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Mental retardation
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Vision difficulties
<input type="checkbox"/>	Hearing difficulties	<input type="checkbox"/>	Other (please specify)
<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	Other (please specify)

PRESENT MEDICAL STATUS

Current Health: \_\_\_\_\_ (Please rate poor, fair, good, excellent, etc.)

Present height: \_\_\_\_\_ weight: \_\_\_\_\_

Are you in any way physically ill at this time? YES\_\_ NO\_\_ If yes, please explain and specify if you are currently being treated for this illness: \_\_\_\_\_

Please list any medication you are currently taking:

<u>Medication</u>	<u>Dose (e.g. 20mg four times a day)</u>	<u>Date Started</u>

Do you currently smoke? \_\_\_\_\_ If yes, how much do you smoke per day and what brand of cigarettes? \_\_\_\_\_

If no, did you ever smoke? \_\_\_\_\_ If yes, how much did you smoke per day, for how long and what brand of cigarettes? \_\_\_\_\_

Are you currently, or have you ever been involved in any type of professional mental health treatment (i.e., psychotherapy, family counseling, etc.)? YES \_\_\_\_ NO \_\_\_\_ If yes, please list:

<u>Clinic</u>	<u>Date(s) seen</u>	<u>Contact Person</u>	<u>Phone Number</u>

EDUCATIONAL HISTORY:

Highest degree earned: \_\_\_\_\_

Name of School: \_\_\_\_\_

Did you repeat any grades? YES \_\_\_\_ NO \_\_\_\_ If yes, which ones and for what reason(s)? \_\_\_\_\_

Did you fail any subjects? YES \_\_\_\_ NO \_\_\_\_ If yes, which ones? \_\_\_\_\_

Did you receive special education services? YES \_\_\_\_ NO \_\_\_\_ If yes, specify type (i.e., self-contained class, resource room, reading or math lab, etc.):

Please indicate if you or any member of your family has had any of the following educational problems.

<input checked="" type="checkbox"/>	<u>Condition</u>	<input checked="" type="checkbox"/>	<u>Condition</u>
<input type="checkbox"/>	Attention problems	<input type="checkbox"/>	Math difficulties
<input type="checkbox"/>	Discipline problems	<input type="checkbox"/>	Reading difficulties
<input type="checkbox"/>	Failing grades	<input type="checkbox"/>	Social situations
<input type="checkbox"/>	Failing subjects	<input type="checkbox"/>	Writing difficulties

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