

ADULT INTAKE QUESTIONNAIRE

Information requested on this questionnaire is an important part of your evaluation. I appreciate your filling it out carefully and fully. Please feel free to add as much information as you want and to use the backs of pages if necessary.

The highest standards of professional confidentiality are maintained. Information about any particular individual can be released only with the explicit written consent of that person except in exceptional legal circumstances. When consent to release information is granted, you may choose which information may/may not be released, and revoke that consent at any time.

Identifying information

Today's Date _____
Birthdate: ____/____/____
Weight: _____ Age: _____
Gender: M F Other Handedness: R L Height: _____
Marital Status: _____ Ethnicity: _____
Cell Phone Number _____
Current address: _____
Home Phone Number _____
City _____ State _____ Zip _____
Permanent address: _____
Phone Number _____
City _____ State _____ Zip _____
Permission to leave voice mail messages: Cell phone: yes no Home phone: yes no
E-mail address: _____ Use to confirm appt.s? yes no
Who referred you for an evaluation? _____
Why? _____

Have you ever been diagnosed with a learning disability? No Yes: age at initial diagnosis _____
If yes, in what area(s) or subject(s) _____
Have you ever been diagnosed with Attention Deficit Disorder? No Yes: age at initial diagnosis _____
Date of your last psychological evaluation: _____ By whom? _____

Family Background

1. Spouse or Significant Other Information

Name: _____

His/her Occupation: _____

2. Do you have children? No Yes

Names	Ages	Highest grade completed	Difficulties in learning, mood, behavior or other disabilities (describe)

3. Parent information: Were you adopted? No Yes

Father's/Parent 1's information (father or parent 1 who raised you)

Name _____ Cell Phone: _____

Occupation: _____ Highest Educational level: _____

Difficulties in learning? No Yes: Describe _____

Other disabilities or significant difficulties (e.g., physical, psychological, or educational)? No Yes

Describe _____

Mother's/Parent 2's information (mother or parent 2 who raised you)

Name _____ Cell Phone: _____

Occupation: _____ Highest Educational level: _____

Difficulties in learning? No Yes: Describe _____

Other disabilities or significant difficulties (e.g., physical, psychological, or educational)? No Yes

Describe _____

5. Parents' current marital status: _____

If parents are re-married, any significant marital conflicts on either side at the present time? No Yes

6. Other adults living in your parents' homes now/with you? (part – or full-time): No Yes

Name _____ Cell phone: _____

Relationship _____ Occupation _____

Name _____ Cell phone: _____

Relationship _____ Occupation _____

7. Current or recent family stressors/problems: _____

8. What languages were spoken in your home growing up? _____

9. What languages are spoken in your current home? _____

10. Any additional language(s) in which you are proficient? No Yes: _____

11. Do you have brothers or sisters? No Yes (Indicate with * if half-sibling, ** if adopted or step-sibling)

Siblings' Names	Ages	Highest grade completed	Difficulties in learning, behavior, mood or other disabilities (describe)

12. Other significant information about your **biological** family

Please indicate the existence of any of the following conditions in your **biological** family. Indicate the relationship of the person to you (e.g., father, maternal grandmother, etc.) and describe the nature of the condition.

- Reading Problems No Yes Who? _____ What? _____
- Learning Problems No Yes Who? _____ What? _____
- Attention Problems No Yes Who? _____ What? _____
- Behavior Problems No Yes Who? _____ What? _____
- Mental Health Disorders No Yes Who? _____ What? _____
- Mental Retardation No Yes Who? _____ What? _____
- Epilepsy No Yes Who? _____ What? _____
- Serious Chronic Illness No Yes Who? _____ What? _____
- Speech/Language Problems No Yes Who? _____ What? _____
- Drug/Alcohol Abuse No Yes Who? _____ What? _____
- Trouble with the Law No Yes Who? _____ What? _____

Additional comments: _____

Birth History

1. Regarding your mother's pregnancy with you: Any problems, complications or concerns at all? No Yes

Bleeding? No Yes Illness: No Yes: Specify _____

RH Incompatibility? No Yes Accidents: No Yes: Specify _____

Exposure to cigarettes? No Yes: Specify _____

Exposure to alcohol or non-prescription drugs? No Yes: Specify _____

Length of pregnancy: early: how early? _____ on time late: how late? _____

Medications taken? No Yes: Specify _____

Describe any other unusual circumstances, such as bedrest, or any risk factors: _____

2. Your birth

Labor: False? No Yes Induced? No Yes Length: _____

Anesthesia? No Yes Natural? No Yes

Type of birth: Normal? No Yes Breech? No Yes Forceps? No Yes
Caesarean? No Yes Birthweight: _____ Apgar Score: _____
Complications: _____

Color: Normal? No Yes Blue? No Yes
Jaundiced? No Yes: treatment _____

Transfusions? No Yes Incubator required? No Yes: How long: _____

Breathing Problems? No Yes Oxygen required? No Yes: How long: _____

Difficulties sucking, swallowing, or feeding? No Yes: Specify _____

Describe any other unusual circumstances _____

Developmental History Any problems or concerns at all? No Yes

1. At what age did you:

Sit alone: _____ Say your first word: _____
Walk alone: _____ Understand speech: _____
Use 2-word sentences: _____ Stop using baby talk: _____
Become toilet trained during the day: _____
Stop wetting the bed at night: _____

2. Did you have any problems in the following areas:

Learning the names of colors and shapes No Yes Cutting with scissors No Yes
Learning to riding a 2-wheeled bicycle No Yes Learning to tell time No Yes
Learning to climb stairs, hop, or skip No Yes Learning to tie your shoes No Yes
Learning to use zippers or buttons No Yes Separating from your parents No Yes
Reading aloud in class No Yes Making friends No Yes
Learning the names or sounds of letters No Yes Learning to read No Yes
Learning how to write letters or numbers No Yes Learning to count or add No Yes
Learning right and left No Yes Reciting the alphabet No Yes
Learning to rhyme No Yes Learning a 2nd language No Yes

Describe anything else hard for you to learn as a preschooler: _____

3. Did your family, friends, etc. ever have difficulty understanding your speech? No Yes: Explain: _____

4. Please list any evaluations, special services or therapies that have ever been provided to you – indicate approximate age or grade, duration, and reason or brief description of services:

Occupational Therapy ? No Yes: Age or grade: _____ For how long? _____
Why? _____

Physical Therapy ? No Yes: Age or grade: _____ For how long? _____

Why? _____

Speech/Language Therapy ? No Yes: Age or grade: _____ For how long? _____

Why? _____

Vision Therapy ? No Yes: Age or grade: _____ For how long? _____

Why? _____

Tutoring? No Yes: Age or grade: _____ For how long? _____

Why? _____

Counseling or psychotherapy? No Yes: Age or grade: _____ For how long? _____

Why? _____

5. While in preschool, elementary, middle or high school, did you ever have:

Early Childhood Special Education No Yes: _____

Informal Accommodations No Yes: What grade(s): _____

Remedial Reading Writing Math class(es) No Yes: What grade(s): _____

504 Plan No Yes: What grade(s): _____

IEP No Yes: What grade(s): _____

A meeting to determine your eligibility for special education or a 504 plan that was denied? No Yes

6. Did you receive any formal or informal accommodations in college or graduate school? No Yes

Medical History

1. Childhood illness

Ear infections? No Yes: Age(s): _____ Explain: _____

Frequent colds? No Yes: Age(s): _____ Explain: _____

Allergies? No Yes: Age(s): _____ Explain: _____

Meningitis? No Yes: Age(s): _____ Explain: _____

Encephalitis? No Yes: Age(s): _____ Explain: _____

Whooping cough? No Yes: Age(s): _____ Explain: _____

Scarlet fever? No Yes: Age(s): _____ Explain: _____

Pneumonia? No Yes: Age(s): _____ Explain: _____

2. Have you ever sustained any blows to the head that caused any physical, emotional, or cognitive symptoms such as memory loss, attention problems, disorientation, dizziness, nausea, etc? No Yes: When? _____

Did you ever have a CT or MRI of your brain after any of these injuries? No Yes

3. Have you ever had seizures? No Yes Age: _____
 Did you receive medication? No Yes Specify: _____
 When was your last seizure? _____
 Known cause for your seizures? _____

4. Have you ever been evaluated or treated for any stress, anxiety, depression, or other types of psychological problems? No Yes: Specify _____

5. Have you ever had injuries or accidents requiring medical treatment? No Yes: Specify _____

6. Have you ever been hospitalized? No Yes Age(s): _____
 Why and for how long? _____

7. Any history or alcohol or substance abuse? No Yes: Specify _____

Current Medical Status

1. Describe your present health: _____

2. Are you currently taking any medication, or have you been on medication in the last 5 years?
 No Yes: If yes, please specify type, dosage/frequency, duration of treatment, and reason(s) prescribed:

Type	Dosage/ Frequency	Duration of Treatment	Reason

3. Have you ever taken any prescription medications for your mood, attention or behavior not listed above?
 No Yes: Specify _____

4. Are you allergic to any drugs or foods? No Yes: Specify _____

5. Any problems with hay fever, allergies, sinuses? No Yes: Specify _____

6. How is your appetite? _____
 Any recent changes (increased or decreased)? No Yes: Describe _____

7. Average amount of sleep at night: _____ Is this adequate for you to function well? No Yes
 Any recent changes (increased or decreased)? No Yes: Describe _____

8. When was your last physical exam? _____

9. When was your last vision exam? _____ Do you wear glasses or contacts? No Yes

10. When was your last hearing exam? _____

Educational Background

Elementary, middle, and high school history

List all elementary, middle/junior high, and high schools attended:

School	City	Grades Attended	Public or Private?

1. Did you skip any grades in school? No Yes: Which grade(s)? _____

2. Did you repeat any grades in school? No Yes: Which grade(s)? _____

Why? _____

3. What things were hard for you to learn in elementary school (such as reading, math, writing cursive, succeeding in physical education, making and keeping friends, conduct, completing seatwork)? _____

4. How would your elementary school teachers describe you? _____

5. What things were hard for you in middle/junior high and high school (such as writing compositions, reading long assignments, social skills, oral presentations, foreign language, algebra, geometry, study skills)? _____

6. How would your high school teachers describe you? _____

7. List any suspensions or expulsions from school during elementary, middle, or high school years: _____

Describe any other significant behavior or conduct problems during your elementary and secondary school years: _____

8. High school GPA _____ Average English grades _____ Average Math grades _____

9. High School foreign language: _____ Number of years: _____ Average grades _____

10. List any honors, awards, or other kinds of special recognition you received in high school: _____

11. List any clubs, teams, or organizations you were actively involved with in high school, and briefly describe your involvement: _____

12. Best SAT score (if taken): Verbal _____ Math _____ Writing: _____

List any accommodations: _____

Did you take a prep course? No Yes: Specify _____

13. Best ACT score (if taken): _____ List any accommodations: _____

Did you take a prep course? No Yes: Specify _____

15. Did you drop out of high school? No Yes: Why? _____

16. What kind of high school diploma did you earn: Vocational/regular College Prep GED None yet

17. Any time off between high school and college? No Yes: Specify _____

Post-Secondary / College History

List the schools you have attended since graduating from high school (including current school), the dates of attendance, degree program, major area of study, and GPA.

School	Dates of Attendance	Degree Program	Major	GPA

1. What are your best subjects? _____

2. What are your poorest subjects? _____

3. College foreign language instruction:

Language: _____ Number of years: _____ Average grades _____

4. List any college extracurricular involvements, and the average amount of time spent weekly (including varsity sports): _____

5. List any honors, awards, or other kinds of special recognition you received during your postsecondary years:

6. Any graduate school entrance exams (e.g., LSAT, GMAT, MCAT, GRE)? No Yes: Which? _____

Best scores: _____ List any accommodations: _____

7. Have you ever applied for testing accommodations and been denied? No Yes: Which test(s)? _____

8. Do you routinely use a planner or calendar to keep track of day-to-day tasks and assignments? No Yes

Social-Emotional/Behavioral Status

1. How do you generally spend your spare time? _____

2. Are you satisfied with your current social life? Yes No: Describe: _____

3. Do you have a regular group of friends with whom you socialize? No Yes
4. How many hours a day (average) do you: Watch TV? _____ Play video/computer games? _____
Devote to text messaging? _____ Online social media and/or chat? _____
5. Are you sexually active? No Yes
6. Do you have questions, concerns or struggles with your own gender identity, sexual orientation or preferences? No Yes
7. Currently in a steady or long-term relationship? No Yes
8. Any concerns about friendships / peer relationships? No Yes
9. How many days/week do you exercise? _____ Average time per day, and what do you do? _____

10. How many days/week do you drink alcohol, on average? _____ Do you think it is a problem? No Yes
11. Describe your current recreational drug use _____
12. Describe your history of recreational drug use _____
13. How would you describe your relationship with your parents (check all that apply):
 Difficult Antagonistic Cold/distant Fine, but little contact Close Warm Supportive
14. Do you have any concerns about your own emotional functioning No Yes: Describe: _____

15. How many times a week do you feel really angry? _____ What makes you feel that way? _____
_____ What do you do? _____

15. Are you a worrier? No Yes: What types of types of things do you worry about? _____

16. Would you characterize yourself as: "Driven" Easily stressed Perfectionistic? None of these
17. Do you have trouble "pulling back?" No Yes
18. Describe any nervous habits (nail biting, hair pulling, etc.) _____

19. Any history of bullying? No Yes

5. Any current volunteer activities No Yes: _____

Current Issues and Plans

1. What is your purpose in seeking this evaluation? _____

2. What do you hope will be the outcome of this evaluation? _____

3. What do you think a learning disability is? _____

4. What do you think an Attention-Deficit/Hyperactivity Disorder (ADHD) is? _____

5. How have you coped with your learning problems? _____

6. Have your learning problems interfered with your present (or any previous) job? No Yes: If yes, How? _____

7. Have your learning problems interfered with your present or previous social relationships No Yes: If yes, How? _____

8. How do you best learn things? _____

9. Describe your strengths as you see them: _____

10. Any additional comments: _____

If requesting a comprehensive evaluation, please provide copies of the following records to supplement the information in this questionnaire. The more information that is provided to me, the better I can understand the context of the current difficulties or concerns that are prompting the request for testing. This generally includes:

- Copies of all general educational records – including teacher comments, interim reports, report cards, anything you have or can get. I want all report cards, for all years, and not just end-of-year grades.
- Standardized testing reports – all standardized testing. If accommodations were provided, also provide documentation of this (for example, letters from the College Board, ACT, SSAT, or other testing agency)
- Copies of any special educational records or school accommodation plans– these might include informal and formal accommodation plans, behavior contracts, and for students in public schools, 504 plans and meeting notes, IEP’s and meeting notes, RTI (Response to Intervention) plans and notes, SST/EMT documentation, etc.
- Copies of relevant medical records
- Informal records that can provide some useful background or contextual information, such as relevant emails to/from school or related service providers, emails with teachers/tutors/professors, a screen shot of an online gradebook, etc.
- Work samples – writing samples particularly helpful to include
- All previous evaluation reports whether you agree with the conclusions or not

I have provided complete, true, and accurate information to the best of my knowledge, including all knowledge about previous testing.

I understand that false or inaccurate information, and not answering all questions fully and truthfully may invalidate my evaluation. I also understand that information on this form, and any information provided as part of this evaluation, can be released only to individuals designated by me and with my written consent.

Signature

Date