The Center for Neuropsychology & Counseling P.C.

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 effective treatment. Please read the questions carefully and answer as fully as possible. We will discuss these questions in detail at the time of your intake appointment. Thank you.

PLEASE PRINT

CLIENT'S NAME _____ DATE _____

BIRTHDATE _____ AGE _____ EDUCATION _____

HOME ADDRESS _____

_____

PHONE (H) _____ (W) _____ (C) _____

MARITAL STATUS _____ EMPLOYMENT STATUS _____

REFERRED BY: _____

REFERRAL SOURCE'S PHONE: _____

What are your concerns? Why is it that you are coming to see us today?

_____

_____

_____

_____

_____

What strategies have you tried to help? _____

_____

What questions do you have that you hope we can help you 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? _____

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:

PLEASE LIST EVERYONE WHO LIVES IN YOUR HOME:

NAME	AGE	BIRTHDATE	RELATIONSHIP TO YOU

EMPLOYMENT HISTORY

Occupation	Place of Employment	Years Worked

MEDICAL HISTORY

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

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

Have you ever 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? _____

_____

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: _____

_____

_____

_____

Have you ever experienced seizures or convulsions? YES_____ NO_____ If yes, explain: _____

_____

_____

Were you ever in a coma? YES_____ NO_____ If yes, please explain: _____

_____

_____

Do you suffer from allergies? YES_____ NO_____ If yes, please explain type of allergic reaction and the treatment you are receiving, if any: _____

_____

_____

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:

Medication	Dose (e.g. 20mg four times a day)	Date Started

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? _____

Have you ever been arrested, charged with a crime or been in jail? If so, please explain and specify if you are currently on parole or probation _____

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:

Clinic	Date(s) seen	Contact Person	Phone Number

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.

Condition	Self	Mother	Father	Sibling	Other (please specify)
Attention problems					
Discipline problems					
Failing grades					
Failing subjects					
Math difficulties					
Reading difficulties					
Social situations					
Writing difficulties					

****

Please use this space for any additional information/comments you wish to share with us about yourself: