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Comprehensive Intake Questionnaire for Adult Evaluations

This questionnaire will help me best understand your current difficulties. Read the questions carefully and answer them as fully as possible.

PLEASE NOTE:
-We recommend completing this questionnaire on a computer and not a mobile device.
-We recommend opening this questionnaire in Adobe Acrobat Reader, which can be downloaded here.
-Boxes outlined in red represent required items.
-You can save the information you enter in to this form and it is recommended that you periodically save the document as you complete it, so that you do not unintentionally lose your data. Once it is complete, follow the instructions given to you in email regarding how to upload your completed questionnaire.

Today's Date

PATIENT INFORMATION

Name of patient

If a person other than the patient is completing this form, list name of individual here

Date of Birth

Age

Gender

Home address

Length of time living in your current neighborhood

Home Phone

Work Phone

Cell Phone

Email

Are you right or left handed

Highest level of education completed

CURRENT REFERRAL

Who referred you to the Neuropsychology Center of St. Louis

Briefly state the main concern(s) for which you are presently seeking help:

How long have you had these concerns/difficulties?:

What have you tried to treat/correct these concerns/difficulties?:

What was the outcome of these attempts? What seems to help/make it worse?:

Does this referral have, or have the potential for, legal involvement? *If there is a potential for legal involvement, please note the information related to Legal Cases in the Informed Consent form.*

◯ Yes ◯ Maybe ◯ No

CURRENT FUNCTIONING

Please list any illnesses for which you are currently being treated:

Current learning and/or psychiatric diagnoses (when listing diagnoses, please indicate who diagnosed each condition):

Please list any known neurologic, genetic disorders or other medical diagnoses:

Name of your Primary Care Provider (PCP):
(*No information will be released or obtained without your written permission)*

PCP Phone Number:

Have you ever had a psychiatric or neurological examination? (If so, please provide details below including the date of the evaluation and name of the provider)

If you are under the care of a Neurologist/Psychiatrist, please provide their name here:
(*No information will be released or obtained without your written permission)*

Neurologist'/Psychiatrist's Phone Number:

Do you wear a hearing aid?

◯ Yes ◯ No

Do you wear glasses/contact lenses?

◯ Yes ◯ No

Use the following fields to list all current medications, current dosages and length of time you have been on each medication. Please include both prescription and over-the-counter medications.

Name of medication(s)	**Dose**	**Length of use (dates)**	**Prescribing physician**

If additional space is needed, use the following space:

Are there any changes in your behavior (increased or decreased energy, attention, etc.) when you are on medications? If so, please describe below.

MEDICAL HISTORY

Please list, chronologically, any illnesses diagnosed and their treatments from birth to present. Include any problem that required medical attention above and beyond normal childhood problems (i.e., flus, colds, strep throat).

Age	Diagnosis	Treatment/Outcome

If additional space is needed, use the following space:

Have you ever experienced a head injury?

◯ Yes (continue to answer the following questions specific to head injuries)

◯ No (skip to next question regarding seizures after the horizontal line)

If Yes, complete the following:

Date of head injury

Cause of injury:

Length of time unconscious (if applicable)

Effect of injury on functioning:

List any treatments given:

Did you engage in inpatient rehabilitation?

◯ Yes (see question to the right)

◯ No

If Yes, where did this occur and for how long?

Did you engage in outpatient rehabilitation?

◯ Yes (see question to the right)

◯ No

If Yes, where did this occur and for how long?

Did you or others notice any changes in your behavior, thinking, memory, or personality following this injury? If yes, please describe:

Have you ever had seizures?

◯ Yes (continue to answer the following questions specific to seizures)

◯ No (skip to the question about sleep after the next horizontal line)

Age of onset of seizures

Frequency

Specific diagnosis:

Treatments given:

Do you have any concerns regarding your sleep?

◯ Yes (check off the kinds of concerns you had/have regarding sleep below)

◯ No (skip to the two questions after the next horizontal line)

Sleep concerns (check all that apply):

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Restlessness

☐ Nightmares ☐ Night terrors ☐ Snoring

☐ Sleep walking ☐ Talking in sleep

☐ Other

Please indicate whether you have had any of the following:

	Yes	No
Measles	○	○
German Measles	○	○
Mumps	○	○
Chicken Pox	○	○
Tuberculosis	○	○
Rheumatic Fever	○	○
Diptheria	○	○
Meningitis	○	○
Encephalitis	○	○
Whooping Cough	○	○
Scarlet Fever	○	○
Neurological Concerns	○	○
Migraines/headaches	○	○
Head Injury	○	○
Coma or loss of consciousness	○	○
Seizures/Convulsions	○	○
Sustained high fever	○	○
Any fever above 104°	○	○
Anemia	○	○
Broken bones	○	○
Asthma	○	○
Sinus condition	○	○
Allergies to food	○	○
Allergies to medicine(s)	○	○
Environmental allergies	○	○
Respiratory Conditions	○	○

(Continued from previous page)
Please indicate whether you have had any of the following:

	Yes	No
Frequent colds	◯	◯
Chronic cough	◯	◯
Hay Fever	◯	◯
Sinus Condition	◯	◯
Cardiovascular Conditions	◯	◯
Shortness of breath with exertion	◯	◯
Dizziness with exertion	◯	◯
Heart condition	◯	◯
Heart murmur	◯	◯
Gastrointestinal Concerns	◯	◯
Excessive vomiting	◯	◯
Frequent Diarrhea	◯	◯
Constipation	◯	◯
Stomach Pain	◯	◯
Genitourinary Concerns	◯	◯
Pain with urination	◯	◯
Strong urine odor	◯	◯
Musculoskeletal Concerns	◯	◯
Muscle pain	◯	◯
Clumsy walk	◯	◯
Poor posture	◯	◯
Other muscle problems	◯	◯

(Continued from previous page)
Please indicate whether you have had any of the following:

	Yes	No
Skin concerns	◯	◯
Frequent rashes	◯	◯
Bruise easily	◯	◯
Sores	◯	◯
Severe Acne	◯	◯
Eczema	◯	◯
Speech Concerns/Defects	◯	◯
Stuttering	◯	◯
Unclear speech	◯	◯
Other Speech issue	◯	◯
Accident prone	◯	◯
Teeth grinding	◯	◯
Nail biting	◯	◯
Skin picking	◯	◯
Tics/Twitches	◯	◯
Unusual body movements	◯	◯

Have you ever had brain imaging (CT scan, MRI, etc.)? If Yes, please provide details below. If no, type "No".

Please list any surgeries you have had including the type of surgery and date of surgery.

Please list any medication(s) taken by you in the past for longer than 3 months duration. Be sure to include 1) Name of Previous Medication(s), 2) Dosage and 3) Dates you took the medication.

Name of medication(s)	Dosage (if known)	Length of use (dates)

Use the area below if additional space is needed:

PSYCHIATRIC HISTORY

Please describe any psychiatric or psychological evaluations or treatments received. Indicate the age, the circumstances that required the evaluation/treatment, the treatment given and the outcome (i.e., did the treatment help?). If none, type "None"

Do you have any history of drug or alcohol abuse? If yes, please describe. If no, type "No".

Have you ever attempted suicide? If yes, please indicate when and describe circumstances. If no, type "No".

Have you ever had difficulty or contact with police? If yes, please describe including dates of contact. If no, type "No".

Has the Division of Family Services had any involvement with any family member?
If yes, please explain and provide dates. If no, type "No"

FAMILY HISTORY

Who lives in the home with you?

Relationship status:

☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

☐ Other

If married, how many years:

If separated or divorced, date(s) of separation/divorce:

Are you adopted?

◯ Yes (see question to the right)

◯ No

Age at adoption:

Please complete the following information regarding biological or adoptive parents in the appropriate column:

	Parent 1	Parent 2
Choose one:		
Age/ Age at death		
Highest level of education completed		
Occupation		
Any psychological or psychiatric problem for which treatment was received?		
Any medical diagnoses?		

In the section below, please provide information about any siblings you have.

Relationship	Age	Highest level of education completed	Current Occupation	List any psychological or medical diagnoses

If additional space is needed use the box below.

Have you or any of your relatives experienced difficulties similar to those you are experiencing? If yes, please describe, if not, type "No"

Biological Family

Have there ever been any suicide attempts or completions by parents, siblings, relatives, or close relatives or close friends?

◯ Yes ◯ No

If yes, please describe:

Have any family members (immediate, maternal/paternal grandparents, uncles, aunts, cousins) experienced difficulties from any of the following: inattentiveness or hyperactivity; behavior problems; learning difficulties; etc.

◯ Yes ◯ No

If yes, please describe:

Relationship	Type of Difficulty	Dates and Type of Treatment

Is there any history of alcohol or drug abuse by parents, siblings, or other family members?

◯ Yes ◯ No

If yes, please describe:

Relationship	Dates and Type of Treatment

Have any family members (immediate, maternal/paternal grandparents, uncles, aunts, cousins) been diagnosed with any of the following medical problems: epilepsy; seizures; migraines; diabetes; cancer; congenital abnormalities; genetic conditions, other neurological conditions etc.

◯ Yes ◯ No

If yes, please describe:

Relationship	Diagnosis	Dates and Type of Treatment

Have any family members (immediate, maternal/paternal grandparents, uncles, aunts, cousins) been diagnosed with any of the following psychiatric/psychological problems: psychological, emotional or personality difficulties; depression or bipolar disorder; schizophrenia; developmental disabilities; Autism or Asperger's disorder; Anxiety or "nervousness" etc.

◯ Yes ◯ No

If yes, please describe:

Relationship	Diagnosis	Dates and Type of Treatment

Please provide any additional information about yourself or extended family that might help me understand your needs (medical, behavioral, psychological, educational, and emotional):

DEVELOPMENTAL HISTORY

Pregnancy/Birth History (cont'd)
Pregnancy with you:

Length of pregnancy in weeks

Mother's age at time of your birth

Father's age at time of your birth

Please mark whether any of the following complications occurred during pregnancy with you (check all that apply):

- ☐ Difficulty with conception
- ☐ Excessive vomiting
- ☐ Vaginal bleeding
- ☐ Toxemia
- ☐ German Measles
- ☐ Flu
- ☐ Hospitalization during pregnancy
- ☐ Medication during pregnancy
- ☐ Cigarettes during pregnancy
- ☐ Drugs while trying to conceive (mother)
- ☐ None of the above
- ☐ Other (e.g., Rh incompatibility) _____
- ☐ Abnormal weight gain
- ☐ Excessive swelling
- ☐ Anemia
- ☐ Measles
- ☐ Emotional Problems
- ☐ High blood pressure
- ☐ X-rays during pregnancy
- ☐ Alcohol during pregnancy
- ☐ Other drugs during pregnancy
- ☐ Drugs while trying to conceive (father)
- ☐ Maternal injury

If you marked any complications above, please describe below including (if applicable) what month of pregnancy the complication occurred, what medication(s) was/were taken, the frequency of any tobacco or alcohol use, and the type and frequency of any drugs used during pregnancy.

Were you born in a hospital? ◯ Yes ◯ No

Length of labor (in hours) _____

Birth weight: _____ lbs. _____ oz.

Apgar scores (if known) _____

Condition at birth _____

Number of days in the hospital _____

Check the relevant birth details:

- ☐ Vaginal delivery
- ☐ Caesarean section (C-section)
- ☐ Forceps used
- ☐ Breech birth
- ☐ Induced labor
- ☐ Delivery complications
- ☐ Incubator needed
- ☐ Jaundiced
- ☐ Bilirubin lights
- ☐ Breathing problems right after birth
- ☐ Supplemental oxygen given
- ☐ NICU stay
- ☐ Birth defects
- ☐ Other

If you marked any complications above, please provide any additional relevant details below.

Do you think your current difficulties might be related to pregnancy, labor or delivery?

- ◯ Yes
- ◯ No

If Yes, provide an explanation here:

Did you have frequent ear infections as an infant?

◯ Yes ◯ No

Did you have ear tubes inserted surgically?

◯ Yes ◯ No

Infancy/Childhood

Milestones
Gross Motor, fine motor, and Language milestones:
At what age did you first do the following (in months)?

Turned over		Fed self with spoon		Crawled	
Sat alone		Scribbled		Stood alone	
Understood first words		Spoke first words		Spoke in sentences	

Did you have difficulty learning how to do any of the following (check all that apply):

- ☐ Ride a bike
- ☐ Throw and/or catch a ball
- ☐ Skip, hop jump
- ☐ I did not have any problems learning how to do any of the above

At what age did you master the following? (report as months)

Daytime bladder control

Nighttime bladder control

Daytime bowel control

Nighttime bowel control

Did bed-wetting and/or bed soiling occur after training?

If Yes, until what age?

◯ Yes (answer question to the right)

◯ No

Did you ever receive Occupational Therapy?

If Yes, provide details:

◯ Yes (answer question to the right)

◯ No

Did you ever receive Physical Therapy?

If Yes, provide details:

◯ Yes (answer question to the right)

◯ No

Have you ever received speech and/or language therapy?

If Yes, provide details:

◯ Yes (answer question to the right)

◯ No

Use the space below to provide any other comments/problems regarding infancy or early childhood development:

Did any event, health condition, separation etc. disturb infant/parent bonding or the developing toddler/parent relationship?

◯ Yes ◯ No

If Yes please describe:

EDUCATIONAL HISTORY

Please identify all schools you have attended giving dates of attendance in sequential order.

Name of School	**From (date) To (date)**	**Degree earned**

Briefly describe any problems occurring during school.

Have you ever been retained a grade in school?

◯ Yes ◯ No

Have you ever skipped a grade in school?

◯ Yes ◯ No

Have you had difficulty with reading?

◯ Yes ◯ No

If Yes, please describe:

Have you had difficulty with math?

◯ Yes ◯ No

If Yes, please describe:

Have you had difficulty with writing/spelling?

◯ Yes ◯ No

If Yes, please describe:

Did you like going to school?

◯ Yes ◯ No

Have you ever had psycho-educational testing either by your school district, special school district or by a private practitioner? *If Yes, please forward copies of report(s) for review.*

◯ Yes ◯ No

Have you ever been identified as exceptional, or gifted? *If Yes, please forward copies of report(s) for review.*

◯ Yes ◯ No

Did you ever receive any special education services? *If yes, please forward copies of IEP or 504 plan for review.*

◯ Yes ◯ No

Did you receive any private tutoring outside of the regular school schedule?

◯ Yes ◯ No

If Yes, please provide details:

EMPLOYMENT HISTORY

Please identify all jobs you have had giving dates of employment in sequential order.

Name of Employer	**From (date) To (date)**	**Job Title/Duties**

SOCIAL/EMOTIONAL FUNCTIONING

Please describe your social interactions with others (i.e., friends, spouse, co-workers):

Please check each of the following that are TRUE for you.

- ☐ I have difficulty relating to others.
- ☐ I physically fight a lot with others.
- ☐ I verbally argue a lot with others.
- ☐ I prefer being alone.
- ☐ I have difficulty making friends.
- ☐ I have difficulty maintaining friendships.
- ☐ I have at least one good friend.
- ☐ I like to host others at my house.
- ☐ I have a small group of good friends.

Use the following space to provide any additional comments about your interactions with others.

Please describe any major family or other stressors that may have impacted you in the past or that may be impacting you now:

List any changes which have occurred for you or your family over the last several years (i.e., relocations, deaths, separations, divorce, remarriage, parental job change, someone significant moving out of this area, experience of a traumatic event or witness of a traumatic event, etc.) Please indicate the date and type of event.

Are there any other particularly traumatic or troubling events which have happened in this your life that I should know about in order to understand you better? (please give details, include incidents you feel were traumatic)

Has you ever witnessed violence inside or outside of the home?

◯ Yes ◯ No

Have you ever had psychological counseling or therapy? If yes, please provide details below

Therapist's Name	**Address/Facility**	**Dates and Type of Treatment**

Please list the names, addresses, and telephone numbers of any other professionals consulted/involved in your care. (This does not give me permission to contact them, and they will only be contacted with your written consent.)

Give a brief description of your relationship with:

Mother/Parent 1:

Father/Parent 2:

Step-parent (specify):

Grandparent (specify):

Brother(s) (if applicable):

Sister(s) (if applicable):

Children (if applicable)

What are your areas of greatest accomplishment?

What do you *enjoy doing the most?*

What do you *dislike* doing the most?

Is there any additional information or anything that you feel is pertinent to know regarding your situation/history/ functioning that has not been covered in this questionnaire?

What do you hope will result from seeking comprehensive neuropsychological assessment services?

You have reached the end of the questionnaire. Please save your work by selecting File-->Save or by clicking the save button in the tool bar: