

Adult Form

Demographic Information

Name of Client being evaluated: _____

D.O.B.: _____ Age: _____

Name of person filling out form: _____

Relationship to client: _____

Permanent Home Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Primary Handedness: RIGHT LEFT

Recent History

Purpose of evaluation request:

In your own words, please describe how you have been functioning (in general) over the past 6 months. Please include what is going well and you are having difficulty with:

Birth History:

Place of birth: _____

Vaginal Birth _____ Cesarean Section _____

Complications with birth:

___ None

___ Yes, if so, please describe

Did you suffer any significant illness the first year of life?

___ None

___ Yes, please describe

Developmental Milestones:

Please list the approximate onset of the following:

First words _____

Talking _____

Walking _____

Potty Training _____

Were you a bed wetter? If so, please describe: _____

Below is a brief description of various aspects of development. Please describe if you noticed any atypical development in any of these areas

- **Gross motor:** using large groups of muscles to sit, stand, walk, run, etc., keeping balance, and changing positions.

___ No

___ Yes, if so, please describe:

- **Fine motor:** using hands to be able to eat, draw, dress, play, write, and do many other things.
 No
 Yes, please describe _____

- **Language:** speaking, using body language and gestures, communicating, and understanding what others say.
 No
 Yes, please describe _____

- **Cognitive:** Thinking skills: including learning, understanding, problem-solving, reasoning, and remembering.
 No
 Yes, please describe _____

- **Social:** Interacting with others, having relationships with family, friends, and teachers, cooperating, and responding to the feelings of others.
 No
 Yes, please describe _____

- **Emotional:** Frustration tolerance, expressing happiness, sadness, anger; learning to manage temper in appropriate ways.
 No
 Yes, please describe _____

Academic History

	Name	City/State	Year -- Graduate	GPA/Grades
Grammar	_____			
Middle/ High School	_____			

College _____

Major: _____ Minor: _____

Graduate _____

Degree: _____ Type of Program: _____

Post Graduate Residency Training, Internships, etc: _____

Have you ever been held back?

No
 Yes, please explain _____

Have you ever required private tutoring or special education?

No
 Yes, please explain _____

Have you ever required special academic accommodations?

No
 yes, please explain _____

Please check any of the following that apply to you. If you check an item, please list the age range that you exhibited each behavior:

	No	Yes	Age range
a) frequent anger outbursts	_____	_____	_____
b) distractibility	_____	_____	_____
c) forgetfulness	_____	_____	_____
d) difficulty completing tasks	_____	_____	_____
e) difficulty staying seated	_____	_____	_____
f) makes careless mistakes	_____	_____	_____
g) doesn't listen	_____	_____	_____
h) disorganized	_____	_____	_____
i) difficulty concentrating	_____	_____	_____
j) loses things	_____	_____	_____
k) Anxious, worrying	_____	_____	_____
l) Frequent irritability	_____	_____	_____
m) hitting self	_____	_____	_____
n) hitting others	_____	_____	_____
o) oppositional to parents	_____	_____	_____
p) oppositional to teachers	_____	_____	_____
q) talking too much	_____	_____	_____
r) skipping school	_____	_____	_____
s) stealing	_____	_____	_____

Medical History

Illness history (please include surgeries)

Illness	Age	Duration	Medical Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications

Please list any prescribed medications you have taken in the past 5 years

Name of medication	highest dose taken	Duration of medication trial
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please use back of page if you require more room

Physicians:

Primary Care Physician _____
Affiliated hospital _____

Have you ever been evaluated by a neurologist?

- No
 Yes

If yes,

What was the referral question? _____

What tests were performed (i.e., MRI, EEG)? _____

What were the results? _____

Diagnosis given? _____

Do you have, or have you ever been evaluated by a specialist?

- No
 Yes, If yes, please list below:

Name	Affiliated Hospital	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever experienced seizures?

No

Yes, describe _____

Have you ever experienced a head injury (including "getting their bell rung")

No

Yes, please describe (loss of consciousness? Continued difficulties following? Medical work up?) _____

Do you currently or have you ever suffered from frequent headaches?

No

Yes, please describe _____

Psychiatric History

1. Have you ever been diagnosed with a psychiatric or developmental disorder?

No

Yes, Please list disorder and age of onset: _____

2. Have you ever received outpatient psychiatric treatment?

No

Yes, please describe _____

3. Have you ever received inpatient psychiatric treatment?

No

Yes, please describe _____

4. Have you ever displayed the following? If yes, please describe

	No	Yes	
a) suicidal ideation	_____	_____	_____
b) suicide attempt	_____	_____	_____
c) homicidal ideation	_____	_____	_____
d) visual hallucinations	_____	_____	_____
e) auditory hallucinations	_____	_____	_____
f) paranoia	_____	_____	_____
g) delusions	_____	_____	_____
h) restricted interests	_____	_____	_____
i) sensitivity to noise	_____	_____	_____

Previous Neuropsychological or Psychological Evaluations:

Have you ever received a previous evaluation? Please list below. If you don't have a copy for review, please describe the results below.

Immediate Family History

Father's Name: _____

___ Biological ___ Adoptive

Alive ___ Deceased ___

DOB _____

Occupation _____

Highest level of education ___ < High School ___ High School Grad
 ___ College Degree ___ Master Degree ___ PhD or MD
 ___ Other _____

Mother's Name

___ Biological ___ Adoptive

Alive ___ Deceased ___

DOB _____

Occupation _____

Highest level of education ___ < High School ___ High School Grad
 ___ College Degree ___ Master Degree ___ PhD or MD
 ___ Other _____

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LICENSED PSYCHOLOGIST
NEUROPSYCHOLOGIST

Does the client's biological mother or father have any remarkable medical or psychiatric history, learning issues, or other issues that might be relevant?

Extended Family History

Medical or Neurological History (please list any known medical conditions in your extended family, i.e., maternal grandmother of client, paternal uncle of father, etc):

Psychiatric History (please list any known psychiatric conditions in your extended family, i.e., maternal grandmother of client, paternal uncle of father, etc):

Thank you for your time and careful attention filling out this form. Please bring with you to your appointment.

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LEAVE THIS SECTION BLANK; FOR OFFICE USE

T/A HX

A/D HX
