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# Adult Intake Information

## BASIC INFORMATION

Name: _____ Date: _____

Gender: ☐ Male ☐ Female Race: ☐ White ☐ Black ☐ Other: _____

Birth Date: _____ Age: _____

Home Address: _____ Place of Business: _____

City: _____ Address: _____

Home Phone: _____ Cell Phone _____ Business Phone _____

Who referred you here?_____ Phone: _____

Address: _____

What telephone number do you prefer to be contacted at: _____

In case of emergency contact: (Name) _____ Phone#_____

## PRESENTING PROBLEMS

Briefly describe your current difficulties: _____

_____

_____

_____

_____

_____

_____

How long has this problem been of concern to you? _____ When was this problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Have any other family members had similar problems ☐ Ye ☐ No If yes, whom? _____

Have you received evaluation or treatment for the current problem or similar problems? ☐ Yes ☐ No

If yes, when and with whom? _____

If currently, list address: _____

Are you on any medication at this time? ☐ Yes ☐ No If yes, please write name(s): _____

_____

Describe any major event(s) that might be related to the problem (e.g. death, divorce, abuse, etc.): _____

_____

_____

## DEVELOPMENTAL HISTORY

**As far as you know, were there any problems with your mother's pregnancy or delivery of you?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

_____

**As far as you know, did you walk, talk and sit up on time?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

_____

**Did you have any childhood illnesses?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

_____

**Did you have normal relationships with your peers when you were a child?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

_____

## EDUCATIONAL HISTORY

| **Schools Attended:** | | **Dates** | **Degrees** |
|---|---|---|---|
| **Universities** | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Special Education** ( **Yes** ☐ **No** ☐ )

**If yes, type of class** _____

## MEDICAL HISTORY

**Please list medications below:**

| **MEDICATION** | **AGE** | **REASON PRESCRIBED** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Have you ever suffered from a head injury which caused confusion or loss of consciousness? Yes** ☐ **No** ☐

## MEDICAL HISTORY

**Place a check next to any illness or conditions that you have had. When you check an item, also note the approximate date or age at the time of the illness.**

| ILLNESS OR CONDITION | AGE OR DATES |
|---|---|
| ☐ AIDS or HIV positive | _____ |
| ☐ Allergies | _____ |
| ☐ Anemia | _____ |
| ☐ Aneurysm | _____ |
| ☐ Anoxia | _____ |
| ☐ Arteriovenous Malformation | _____ |
| ☐ Arthritis | _____ |
| ☐ Asthma | _____ |
| ☐ Ataxia | _____ |
| ☐ Automobile Accident | _____ |
| ☐ Back Pains or Problems | _____ |
| ☐ Bleeding Problems | _____ |
| ☐ Blood Disorders | _____ |
| ☐ Bone or Joint Disease | _____ |
| ☐ Broken Bones | _____ |
| ☐ Cancer | _____ |
| ☐ Chorea | _____ |
| ☐ Coma | _____ |
| ☐ Cystic Fibrosis | _____ |
| ☐ Dazed or Unconscious | _____ |
| ☐ Dementia | _____ |
| ☐ Diabetes | _____ |
| ☐ Dysarthria | _____ |
| ☐ Dyspraxia (or Apraxia) | _____ |
| ☐ Ear Infections (PE Tubes) | _____ |
| ☐ Other Ear Problems | _____ |
| ☐ Eczema or Hives | _____ |
| ☐ Encephalitis | _____ |
| ☐ Epilepsy, Seizures, Fits | _____ |

**Indicate if you have undergone any of these medical tests (please check and give age):**

| | |
|---|---|
| ☐ Electroencephalogram (EEG) | _____ |
| ☐ Skull X-rays | _____ |
| ☐ CT Scan | _____ |
| ☐ MRI Scan | _____ |
| ☐ BEAM Study | _____ |
| ☐ Evoked Potentials | _____ |
| ☐ Opthalmological (Vision) | _____ |
| ☐ Audiological Evaluation | _____ |

| ILLNESS OR CONDITION | AGE OR DATES |
|---|---|
| ☐ Fainting spells | _____ |
| ☐ Fetal Alcohol Syndrome | _____ |
| ☐ Fever (if high or prolonged) | _____ |
| ☐ Guillain-Barre Syndrome | _____ |
| ☐ Head Injury | _____ |
| ☐ Headaches | _____ |
| ☐ Heart Disease or Problems | _____ |
| ☐ Lead Poisoning | _____ |
| ☐ Hepatitis | _____ |
| ☐ Herpes | _____ |
| ☐ High Blood Pressure | _____ |
| ☐ Jaundice | _____ |
| ☐ Leukemia | _____ |
| ☐ Malnutrition | _____ |
| ☐ Meningitis | _____ |
| ☐ Muscular Disease | _____ |
| ☐ Pain Problems | _____ |
| ☐ Paralysis | _____ |
| ☐ Pituitary Disorder | _____ |
| ☐ Pneumonia | _____ |
| ☐ Poisoning | _____ |
| ☐ Poliomyelitis | _____ |
| ☐ Rheumatic Fever | _____ |
| ☐ Scarlet Fever | _____ |
| ☐ Sensory Losses | _____ |
| ☐ Sexual Molestation | _____ |
| ☐ Sexually Transmitted Disease | _____ |
| ☐ Speech/Language Problems | _____ |
| ☐ Spells (_____) | _____ |
| ☐ Stroke | _____ |
| ☐ Suicide Attempts or Thoughts | _____ |
| ☐ Sunstroke or Heat Exhaustion | _____ |
| ☐ Thyroid Disorder or Problem | _____ |
| ☐ Trauma (_____) | _____ |
| ☐ Tuberculosis | _____ |
| ☐ Tumor | _____ |
| ☐ Visual Problems | _____ |
| ☐ Whooping Cough | _____ |

**OTHER MEDICAL PROBLEMS(S):**

_____

**Physician's name and address:** _____

## FAMILY HISTORY

**Are there any medical illnesses that run in your family?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has had problems with anxiety or depression?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has abused alcohol or other drugs?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has had any psychiatric illness?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has been in trouble with the law?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has had seizures or other neurological problems?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has had Tourette's syndrome or vocal tics?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has a movement disorder or any unusual movements?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has had heart problems?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has high blood pressure?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has had attentional problems?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**Is there anyone in your family who has had learning disabilities?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

## SOCIAL HISTORY

**How much do you smoke?**

- ○ Never smoked
- ○ Have quit for more than a year
- ○ Have quit for less than a year
- ○ Less than half a pack per day (ppd)
- ○ Half to one ppd
- ○ One to two ppd
- ○ Two or more ppd

**How much caffeine do you drink, including caffeinated tea and soda?**

- ○ None
- ○ 1-2 cups per day
- ○ 3-4 cups per day
- ○ 5-6 cups per day
- ○ 7-10 cups per day
- ○ 11 + cup per day

**Briefly describe your work history, starting as far back as you can remember.**

_____

_____

_____

_____

**Have you served in the military?**

**Yes** ☐ **No** ☐ **If yes, details (highest rank, special honors, duties, discharge status):**_____

_____

_____

_____

**Have you ever been in trouble with the law?**

**Yes** ☐ **No** ☐ **If yes, details** _____

_____

_____

**What is your current marital status?**

- ○ Never married
- ○ Married
- ◉ Separated
- ○ Divorced
- ○ Widowed

**List names and ages of children**

_____

_____

_____

**Are you currently in an intimate relationship?**

**Yes** ☐ **No** ☐ **If yes, for how long?**

- ○ Less than 3 months
- ○ 3-6 months
- ◉ 7 months – 1 year
- ○ 1-5 years
- ○ 5-10 years
- ○ 10+ years

**Do you have trouble in your relationships with others?**

**Yes** ☐ **No** ☐ **If yes, details:** _____

**How many intimate relationships have you had that lasted more than 3 months?**

- ◯ **None**
- ◯ **One or two**
- ◯ **Three or four**
- ◯ **Five or more**

**You have been asked a lot of questions. Can you think for a minute and describe any other problems you have that might be related to what you came here for?**