

Arrowhead Psychological & Behavioral Sciences, LLC
Neuropsychology Intake Questionnaire
Adult Data Form

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Gender (circle one): Male Female

Religion: _____ Social Security#: _____

Person filling out this form (circle one): Mother Father Stepmother Stepfather Guardian

Other (please explain): _____

Parents / Guardians / Family (Please circle Birth, Adoptive, or Foster)

Birth / Adoptive / Foster Mother's Name: _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Birth / Adoptive / Foster Father's Name: _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Stepmother's Name: _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Stepfather's Name: _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Other Guardian Name(s): _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Relationship to Patient: _____

List all people living in household with patient:

<i>Name</i>	<i>Relationship to patient including biological, foster, adoptive</i>	<i>Age</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary language spoken in the home: _____

Other languages spoken in the home: _____

Foster / Adoptive Information

(Please complete this information if the patient has ever been adopted or placed in foster care)

What age was the patient first placed in foster care? _____

If the patient is adopted, what age was the patient first adopted? _____

How many different foster care / adoptive placements has the patient experienced? _____

What type of placements has the patient experienced (e.g., orphanage, foster home, group home, shelter care, kinship home, hospitalization, etc.): _____

If the patient was adopted, do they know they were adopted? Yes ____ No ____

Does the patient have any contact with biological parents? Yes ____ No ____

How did the patient adjusted to foster care / adoption? _____

Referral Information

Briefly describe the patient’s current difficulties as you see them: _____

How long has this been of concern to you? _____

What seems to help this situation? _____

What seems to make this situation worse? _____

Has the patient received evaluation or treatment for the current issue or similar issues? Yes _____ No _____

If yes, when and with whom? _____

Is the patient on any medication at this time? Yes _____ No _____

If yes, list medication (s), dosages, and name of professional monitoring your patient’s medication:

Who referred you to the Arrowhead Psychological & Behavioral Sciences, LLC

What kind of services are you seeking for the patient (for example, change in school placement, therapy, psychological testing, medication, etc.)? _____

What is important for those involved in testing the patient to know about him or her?: _____

Describe the best things about the patient: _____

Write about something the patient does well: _____

Have there been any major changes within the family life or the patient's living situation that have affected the patient's development (e.g., deaths, moves, divorces, loss of job, etc)? _____ No _____ Yes (describe below)

EVENT _____ DATE _____ PATIENT'S AGE _____

Pregnancy / Developmental History

Length of pregnancy (e.g., full term, 34 weeks, 30 weeks, etc.) _____

Length of delivery (number of hours from initial labor pains to birth): _____

Age of mother at pregnancy: _____

Place of birth: _____

Patient's birth weight: _____

Apgar Scores: 1 minute _____ 5 minutes _____

Did any of the following conditions occur during pregnancy / delivery?

_____ No _____ Yes

Bleeding

_____ No _____ Yes

Toxemia / preeclampsia

_____ No _____ Yes

Rh factor incompatibility

_____ No _____ Yes

Frequent nausea or vomiting

_____ No _____ Yes

Serious illness or injury

_____ No _____ Yes

Took prescription or over the counter medication – If yes, name of medication(s) _____

_____ No _____ Yes

Took recreational drugs – If yes, name of drug(s) _____

_____ No _____ Yes

Used alcoholic beverage – If yes, approximate number of drinks per week _____

_____ No _____ Yes

Smoked cigarettes – If yes, approximate number of cigarettes per day _____

_____ No _____ Yes

Was given medication to ease labor pains – If yes, name of medication(s) _____

_____ No _____ Yes

Delivery was induced

_____ No _____ Yes

Forceps were used during delivery

No Yes Had a breech delivery
 No Yes Had a cesarean section delivery – reason _____
 No Yes Other problems – please describe _____

Did any of the following conditions affect the patient during delivery or within the first few days after birth?

No Yes Injured during delivery – If yes, please describe _____

No Yes Cardiopulmonary distress during delivery

No Yes Delivered with cord around neck

No Yes Had trouble breathing following delivery

No Yes Needed oxygen

No Yes Turned blue

No Yes Was jaundiced, turned yellow

No Yes Had an infection

No Yes Had seizures

No Yes Was given medication – If yes, name of medication(s) _____

No Yes Born with a congenital defect – If yes, please describe _____

No Yes Was in hospital more than 7 days

Have you ever been told that the patient might have developmental problems? No Yes (specify)

At what age did the patient begin to do the following? *Please indicate age.*

_____ Turn over

_____ Walk down stairs

_____ Sit up alone

_____ Use single words (e.g., “mama”, “dada”, “ball”, etc.)

_____ Crawl

_____ Put two or more words together (e.g., “mama up”, etc.)

_____ Stand alone

_____ Bowel trained, day and night

_____ Walk alone

_____ Bladder trained, day and night

_____ Walk up stairs

Did the patient have day time toileting accidents after toilet training? Yes _____ No _____

If yes, at what age? _____

Did bed-wetting occur after toilet training? Yes _____ No _____ If yes, until what age? _____

Did bed-soiling occur after toilet training? Yes _____ No _____ If yes, until what age? _____

Were there any medical reasons for day time accidents, bed-wetting or soiling? Yes _____ No _____

If yes, please describe.

Infant / Toddler Temperament

During the first three years of life, in comparison to other children of the same age, was the patient

Difficult to feed _____ Less Often _____ About the same _____ More

Difficult to get to sleep _____ Less Often _____ About the same _____ More

Colicky _____ Less Often _____ About the same _____ More

Difficult to put on a schedule _____ Less Often _____ About the same _____ More

Alert _____ Less Often _____ About the same _____ More

Cheerful _____ Less Often _____ About the same _____ More

Affectionate _____ Less Often _____ About the same _____ More

Sociable _____ Less Often _____ About the same _____ More

Easy to comfort _____ Less Often _____ About the same _____ More

Difficult to keep busy _____ Less Often _____ About the same _____ More

Overactive, in constant motion _____ Less Often _____ About the same _____ More

Very stubborn, challenging _____ Less Often _____ About the same _____ More

Apt to cry excessively _____ Less Often _____ About the same _____ More

Emotionally responsive _____ Less Often _____ About the same _____ More

Easy to discipline _____ Less Often _____ About the same _____ More

Was the patient adaptable, easy to please and easy to discipline as an infant and toddler? _____ No _____ Yes

If no, please describe: _____

As an infant and toddler, was the patient interested in social contact (eye contact, social smile, showing things, sharing experiences)? _____ No _____ Yes

If no, please describe: _____

As an infant and toddler, describe the patient regarding his/her ease of self-regulation (e.g., ability to settle down at night, calm self when emotionally shaken, etc.)? _____

Patient’s Medical History

Place a check next to any illness or condition that the patient has had. When you check an item, also note the approximate date (or age) of the illness.

<i>Check if yes</i>	<i>Illness or condition</i>	<i>Date(s) or age(s)</i>	<i>Check if yes</i>	<i>Illness or condition</i>	<i>Date(s) or age(s)</i>
_____	Measles	_____	_____	Dizziness	_____
_____	German measles	_____	_____	Frequent or severe headaches	_____
_____	Mumps	_____	_____	Difficulty concentrating	_____
_____	Chicken Pox	_____	_____	Memory problems	_____
_____	Whooping cough	_____	_____	Extreme tiredness or weakness	_____
_____	Diphtheria	_____	_____	Rheumatic fever	_____
_____	Scarlet fever	_____	_____	Epilepsy	_____
_____	Meningitis	_____	_____	Tuberculosis	_____
_____	Encephalitis	_____	_____	Bone or joint disease	_____
_____	High Fever (over 104)	_____	_____	Gonorrhea or syphilis	_____
_____	Convulsions	_____	_____	Anemia	_____
_____	Allergy	_____	_____	Jaundice/hepatitis	_____
_____	Hay fever	_____	_____	Diabetes	_____
_____	PE Tubes (how many)	_____	_____	Cancer	_____
_____	Broken bones	_____	_____	High blood pressure	_____
_____	Hospitalizations	_____	_____	Heart disease	_____
_____	Operations	_____	_____	Asthma	_____
_____	Ear problems (disease, infection, injury, or impaired hearing)	_____	_____	Bleeding problems	_____
_____	Visual problems	_____	_____	Eczema or hives	_____
_____	Fainting spells	_____	_____	Suicide attempt	_____
_____	Loss of consciousness	_____	_____	Pregnancy	_____
_____	Paralysis	_____	_____	Other _____	_____
_____	Injuries to head	_____			

Please describe the head injury, was there loss of consciousness, did it require sutures, did it result in a concussion, etc. _____

Please describe other serious illnesses, need for stitches, or operations:

Illness / Operation

Age

Has the patient ever been on long-term medication (more than 6 months)? Yes _____ No _____

If yes, when? _____ What kind? _____

CURRENT MEDICAL:

Please indicate whether the patient has had any of the following problems within the last two years. If yes, describe the severity and how often these problems have occurred.

Respiratory

_____ Frequent colds _____

_____ Chronic cough _____

_____ Asthma _____

_____ Hay fever _____

_____ Sinus condition _____

Cardiovascular

_____ Shortness of breathe
dizziness with physical
exertion _____

_____ Activity limitation due
to heart condition _____

_____ Heart murmur _____

Gastrointestinal

_____ Excessive vomiting _____

_____ Frequent diarrhea _____

_____ Constipation _____

_____ Stomach pain _____

Musculoskeletal

- _____ Muscle pain _____
- _____ Clumsy walking _____
- _____ Poor posture _____
- _____ Other muscle problems: Describe _____

Neurological

- _____ Seizures/convulsions _____
- _____ Speech defects _____
- _____ Accident prone _____
- _____ Has tics/twitches _____
- _____ Rocks back and forth _____

Allergies

- _____ Allergy to medicine _____
- _____ Allergy to food _____
- _____ Other allergies _____

Hearing

- _____ Ear infections _____
- _____ Hearing problems _____
- Date of most recent hearing exam _____ Results: _____

Vision

- _____ Vision problems _____
- _____ Wears glasses or contacts _____
- Date of most recent vision exam _____ Results: _____

Medical Care

Patient's physician _____ Telephone _____

Physician's mailing Address _____

How often does the patient see a doctor? _____ Date of last visit _____

Has the patient ever had psychological counseling or therapy? Yes _____ No _____

If yes, counselor's name _____

Counselor's Address _____

Telephone _____

Type of counseling and for what issues _____

When _____

Did you find it helpful? _____ No _____ Yes

Has the patient ever attempted suicide? Yes _____ No _____

If yes, When _____ How _____

Please describe the circumstances that led up to the suicide attempt: _____

Did the patient receive any therapy after this suicide attempt? Yes _____ No _____

Has the patient ever talked about wanting to hurt him or herself? Yes _____ No _____

If yes, When _____

Please describe the circumstances that lead up to the suicide ideation: _____

Did the patient receive any therapy after talking about harming themselves? Yes _____ No _____

Has the patient ever had a neurological exam? Yes _____ No _____

If yes, neurologist's name _____ Date of Exam _____

Neurologist's Address _____

Reason for exam _____

Results of exam _____

Has the patient ever had a psychological or psychiatric evaluation? Yes _____ No _____

If yes, doctor's name _____ Date of Eval _____

Doctor's Address _____

Reason for exam _____

Has the patient ever been hospitalized in a psychiatric facility? Yes _____ No _____

If yes, When? _____ Where? _____

Reason? _____

Please list any and all diagnoses the patient has been given (e.g., AD/HD, Learning Disabled, PDD, Tourette's, Bipolar, Depression, Anxiety, Asperger's, Autism, etc.):

Family Medical History

Place a check next to any illness or condition that any member of the extended family has had. When you check an item, please specify family member's relationship to the patient (**please include "M" if the relative is from the mothers side or "P" if the relative is from the father's side: example – M. Aunt would be for the patient's aunt from the mother's side of the family**).

<i>Check if yes</i>	<i>Condition</i>	<i>Relationship to patient</i>	<i>Check if yes</i>	<i>Condition</i>	<i>Relationship to patient</i>
_____	Alcoholism	_____	_____	Depression	_____
_____	Cancer	_____	_____	Suicide attempt	_____
_____	Diabetes	_____	_____	Heart trouble	_____
_____	Cystic fibrosis	_____	_____	High blood pressure	_____
_____	Kidney disease	_____	_____	Migraine headaches	_____
_____	Multiple sclerosis	_____	_____	Stroke	_____
_____	Tuberculosis	_____	_____	Alzheimer's disease	_____
_____	Hemophilia	_____	_____	Huntington's chorea	_____
_____	Muscular dystrophy	_____	_____	Parkinson's disease	_____
_____	Sickle-cell anemia	_____	_____	Tay-Sachs disease	_____
_____	Tourette's syndrome	_____	_____	Birth defect	_____
_____	Cerebral palsy	_____	_____	Behavior disorder	_____
_____	Emotional disturbance	_____	_____	Mental illness	_____
_____	Mental retardation	_____	_____	Nervousness/Anxiety	_____
_____	Seizures or epilepsy	_____	_____	Reading problem	_____
_____	Other learning disability	_____	_____	Severe head injury	_____
_____	Substance abuse	_____	_____	Substance addiction	_____
_____	Thought problems	_____	_____	Schizophrenia	_____

_____ Other: Describe _____

Has anyone in the family ever been in special education services? Yes _____ No _____

If yes, who? _____ What type of services? _____

Has anyone in the family ever completed suicide? Yes _____ No _____

If yes, who? _____ When? _____

Has anyone in the family ever been hospitalized in a psychiatric facility? Yes _____ No _____

If yes, who? _____ When? _____

Has anyone in your family witnessed domestic violence? Yes _____ No _____

If yes, who? _____ When? _____

Please describe the domestic violence: _____

Has the patient ever experienced any type of abuse (e.g., physical, emotional, sexual, neglect)? _____ No _____ Yes

If yes, what type(s)? _____

When? _____

Please describe _____

Social and Behavior Checklist

Place a check next to the following categories indicating whether you see this area as a strength or an area of concern for the patient.

Strength / Concern

Strength / Concern

_____ _____ interactions with peers

_____ _____

interactions with brothers and sisters

_____ _____ anger management

_____ _____

interaction with strangers

_____ _____ activity level

_____ _____

attention

_____ _____ persistence

_____ _____

planning activities / projects / tasks

_____ _____ energy level

_____ _____

self-control

_____ _____ problem solving

_____ _____

interaction with authority figures

_____ _____ expressing feelings

_____ _____

discussing fears

Since age 5 has your patient ever demonstrated: _____ N/A, my patient is not 5 years old yet.

_____ No _____ Yes Anxiety or Oversensitivity to new experiences

_____ No _____ Yes Verbal aggression such as profanity, making threats and/or disruptive vocalizations

_____ No _____ Yes Lack of attentiveness

_____ No _____ Yes Wandering, running away, roaming

_____ No _____ Yes Hyperactivity – inability to sit still or restlessness

_____ No _____ Yes Engages in compulsive rituals

If yes, please describe: _____

_____ No _____ Yes Inability to make friends

_____ No _____ Yes Physical aggression such as hitting, biting, pinching, kicking, spitting

_____ No _____ Yes Constant fighting with siblings or peers

_____ No _____ Yes Property destruction

- No Yes Extreme withdrawal – social isolation – shyness
- No Yes Sudden weight gain or loss
- No Yes Eating objects which are not meant to be eaten
- No Yes Self-injurious behavior such as head banging, head slapping, hair pulling, cutting
- No Yes Nervous habits such as tics; If yes, please describe: _____

- No Yes Thumbsucking
- No Yes Grinding teeth, clicking teeth

Please explain any yes responses:

Do you have concerns related to your patient’s ability to control their temper (i.e., tantrums)? Yes No

If yes, please describe your concerns: _____

Educational History

What age did your patient start going to school? _____

How did your patient react to starting school? _____

School History: (please write in the names of the schools with the approximate dates of attendance)

Pre-school: _____ Dates _____

Kindergarten: _____ Dates _____

Elementary: _____ Dates _____

_____ Dates _____

Middle School: _____ Dates _____

_____ Dates _____

High School: _____ Dates _____

_____ Dates _____

College/Vo-Tech: _____ Dates _____

_____ Dates _____

Current School: _____ Current Grade: _____

Current Teacher or other school contact: _____ Phone: _____

Please check what you feel best describes the patient in the following areas currently or while in school:

ATTENDANCE	ABILITY	RELATIONS WITH CLASSMATES	BEHAVIOR
Rarely absent	Above Average	Above Average	Above Average
Sometimes absent	Average	Average	Average
Often absent	Below Average	Below Average	Below Average

Place a check next to the following categories indicating whether you see the area as a strength or an area of concern for the patient.

<i>Strength / Concern</i>	<i>Strength / Concern</i>
_____ _____ Reading	Other subjects (please list below)
_____ _____ Arithmetic	_____ _____ _____
_____ _____ Spelling	_____ _____ _____
_____ _____ Writing	_____ _____ _____
_____ _____ Relationship with teachers	_____ _____ _____

Has the patient received any special education services (e.g., title I, 504 Accommodations, speech/language, adaptive physical education, occupational therapy, classroom aide, etc)? Yes _____ No _____

If yes, what type of service (s)? _____

When did the school last evaluate your patient? _____

Has the patient been retained in a grade? Yes _____ No _____

If yes, which grade(s) and why? _____