

Twin State Psychological Associates

Springfield, VT 05156

Phone: 802-885-5719

Adult Intake Information Form

Please bring this completed questionnaire with you at the time of your first appointment. Thank you.

Name _____ Date _____

Address _____ Phone _____
City/Town State

Date of Birth _____ Age _____ Sex _____ Race _____

Occupation _____

Who referred you? _____

Emergency Contact _____ Phone _____

Primary Support Group

Marital Status: Married _____ Divorced _____ Never Married _____ Other _____

If Married, Length of Current Marriage: _____ Number of Times Married: _____

Partner's Name: _____ Age: _____ Education: _____

Partner's Occupation: _____

List All Children In Your Current Family

Name	Age	Education (In years)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Problem(s) Seeking Consultation For

1. _____
2. _____
3. _____

Any prior assessments? If yes, date and by whom? _____

_____ (Bring reports to assessment)

Name: _____

Employment

Are you working? _____ Employer _____

Prior occupation(s) _____

Number of jobs in last 5 years: _____ Any trouble holding down a job? _____

Any work related problems (specify)? _____

Family History

1. Number of siblings: _____ Ages: _____
2. Parents' marital status: _____
3. Father's occupation and education: _____
4. Mother's occupation and education: _____
5. Describe what growing up in your family was like: _____

Neurodevelopmental History

Mother's pregnancy:

Length of mother's pregnancy (check one): 37+ weeks ___; 32 to 37 weeks ___; less than 32 weeks ___ .

Birth weight _____

Type of delivery _____

Birth Complications? _____

Did mother smoke during pregnancy? _____

Did mother use alcohol or drugs? _____

Check any of the following you had a childhood history of and give age[s] at which they occurred:

- | | | |
|---|------------------------|--|
| Motor clumsiness _____ | Delayed speech _____ | Stuttering _____ |
| Bedwetting _____ | Ear infections _____ | Trouble making friends _____ |
| Extreme shyness _____ | Conduct problems _____ | Reading problems _____ |
| ADHD _____ | Using tools _____ | Problems with mathematics _____ |
| Word finding _____ | Speech _____ | Telling right from left _____ |
| Understanding conversation when talking _____ | | Obsessive interests in childhood _____ |
| Problems related to parent's separation _____ | | |
- How was your memory in childhood? Excellent _____ Good _____ Fair _____ Poor _____
- How did you learn best? Reading _____ Visual Diagrams _____ Hearing information _____
Observing _____ Other _____

Name: _____

Education

Did you graduate from high school? _____ What year did you graduate? _____

If you are a student, what year are you in? _____

Name of college (s) _____ Date of graduation _____

Major (s) _____

Did you have any trouble with:

Learning how to read? _____

Learning how to spell? _____

Learning how to do math? _____

Were you ever diagnosed with a learning disability? ___ If yes, when and what disability? _____

Were you ever in a special school or class, receive tutoring or repeat a subject or grade? _____

Describe your grades in:

- Elementary school _____
- High school _____
- College _____

What were your:

- Best subject(s) _____
- Worst subject(s) _____

Standardized test scores (if taken and known):

- SAT Verbal _____
- SAT Math _____
- GRE Verbal _____
- GRE Math _____
- Other _____

Age you completed high school? _____

Age you completed college? _____

List special talent(s): e.g., sports, music, artistic, math, writing, dance: _____

Past Psychological History

1. Have you been previously diagnosed with a psychological problem? ____ Details:
2. Have you ever seen a mental health professional? ____ Details:
3. Have you been exposed to a traumatic event(s), including physical, sexual or emotional/verbal abuse that involved actual or threatened serious psychological or physical injury to yourself or another close to you? Yes ____ No ____ (Check one)
If yes, specify the dates, frequency and duration of the trauma:
4. Have you ever had problems with depression? . Details:
5. Have you ever had any suicidal thoughts? ____ Details:
6. Have you ever had any suicidal attempts? ____ Details:
7. Have you ever had any thoughts of seriously physically hurting another person? . Details:
8. Have you ever had problems with anxiety? _____ Details:

Other Psychological Concerns

	Never	Past	Current
* Prolonged periods of sadness			
* Excessive anxiety, fears, phobias			
* Panic/anxiety attacks			
* Obsessions/preoccupations			
* Compulsive habits/rituals			
* Delusions			
* Hallucinations			
* Other - Specify:			

Alcohol, Drug Abuse and Addictions

History of Alcohol Use

On average, how much alcohol (beer, wine, liquor) do you drink a week? _____

Have you abused alcohol? _____ For how many years? _____

Age drinking became a problem _____ Any blackouts? _____

Any withdrawal symptoms: i.e., rapid heart, sweating, etc.? _____

Any drinking related problems, e.g., health, family life job? _____

Drinking still a problem? _____ If no, what age did abuse stop? _____ Attendance at AA? _____

If drinking, is it still a problem, any attempt to stop drinking? _____

Do you drive with someone who is drinking? _____

Have you had any treatment for alcohol abuse? _____ # hospitalizations? _____

History of Drug Use

Have you abused drugs? _____ How many years? _____ Age drug abuse became a problem: _____

List Drugs Used: _____

Have you had treatment for drug abuse: _____ # hospitalizations? _____

Attendance at NA/AA? _____ Attendance OA? _____

History of Other Addictions

Any treatment for eating disorder? _____ # hospitalizations? _____

Any treatment for gambling? _____ Describe: _____

Describe Any Other Addictions: _____

Describe any Legal Interventions related to alcohol, drug or other addictions: _____

Name: _____

Medical History (Please check all that apply)

- | | | |
|----------------------------|-----------------------------|------------------------------|
| High blood pressure _____ | Heart disease _____ | Cancer _____ |
| MS _____ | Lupus _____ | HIV _____ |
| Respiratory problems _____ | Circulation problems _____ | Diabetes _____ |
| Arthritis _____ | Problems with Vision _____ | Chronic Fatigue _____ |
| Ear Infections _____ | Tubes in Ears _____ | Temper Tantrums _____ |
| Stuttering _____ | Meningitis _____ | Stomach Aches _____ |
| Eating Disorder _____ | Trouble Sleeping _____ | Coordination Problems _____ |
| Delayed Speech _____ | Bedwetting _____ | Loss of Consciousness _____ |
| Hearing Problems _____ | Allergies _____ | Motor Vehicle Accident _____ |
| Suicidal Thoughts _____ | Suicidal Attempts _____ | Homicidal Thoughts _____ |
| Chronic Headaches _____ | Sleep disorder _____ | Seizures _____ |
| Sleep Apnea _____ | Blurred vision _____ | |
| Febrile Seizures _____ | Contact Sports Injury _____ | |

Please describe other problem(s)? _____

Any surgery? ____ If yes, date(s) and procedure(s)? _____

Current Medications and Dosages	Reason for medication
(1) _____	(1) _____
(2) _____	(2) _____
(3) _____	(3) _____

Ever taken medication for? Depression ____ Anxiety ____ Panic ____ ADHD ____
Bipolar Disorder ____ Other psychiatric medications?: _____

Family Medical History Please identify family medical history for first and second degree relatives(s) listed below using the following Codes:

Code

Family History of First Degree Relatives:

- * Mother (M)
- * Father (F)
- * Biological Sister (S1, S2, S3)
- * Biological Brother, (B1, B2, B3)

Family History of Second Degree Relatives:

- * Maternal Grandmother (MGM)
- * Maternal Grandfather (MGF)
- * Paternal Grandmother (PGM)
- * Paternal Grandfather (PGF)
- * Maternal Uncle (Mother's Brother MU 1 ,2 ,3)
- * Maternal Uncle (Mother's Brother MU 1 ,2 ,3)
- * Maternal Aunt (Mother's Sister MA 1, 2, 3)
- * Paternal Uncle (Father's Brother PU 1, 2, 3)
- * Paternal Aunt (Father's Sister PA 1, 2, 3)

Seizures _____

Attention Deficit Hyperactivity Disorder _____

Headaches _____

Bipolar Disorder _____

Depression _____

Mental Retardation _____

Known Sexual Abuse _____

Left Handedness _____

Anxiety _____

Alcohol Abuse _____

Spent Time in Prison _____

Arthritis _____

PMS _____

Nightmares _____

Lyme Disease _____

Parkinson's Disease _____

Loner or Few Friends _____

Used Psychiatric Medication _____

Thyroid Disease _____

Cancer _____

Sleep Disorder _____

Sleep Apnea _____

Liver Disease _____

Tic Disorder _____

Odd or Eccentric Behavior _____

Problems with Mathematics _____

Problems at Menopause _____

Obesity _____

Tourettes Syndrome _____

Fatigue _____

Memory Problems _____

Alzheimer's Disease _____

Eating Disorders _____

Obsessive Compulsive Disorder _____

Anxiety _____

Autism _____

Known Physical Abuse _____

Bowel Control Problems _____

Schizophrenia _____

Drug Abuse _____

Heart Disease _____

Difficulty Falling Asleep _____

MS _____

Inborn Errors of Metabolism _____

Huntington's Disease _____

Hypertension _____

Violent Behavior _____

Learning Disabilities _____

Diabetes _____

Lupus _____

Early Morning Awakening _____

Meningitis/Encephalopathy _____

HIV / AIDS _____

Stroke _____

Allergies _____

Poor Sense of Direction _____

Polysubstance Abuse _____

Gambling Behavior _____

History of Miscarriages _____

Fibromyalgia _____

Neurological History

Have you ever had memory problems? If so, please describe: _____

Have you been in a car accident? _____

Ever play contact sports (football, hockey)? _____

Any history of head injury or concussion? _____ What age (s)? _____ Number of head injuries _____

Any loss of consciousness? _____ How long unconscious? _____

Any treatment or hospitalization for the head injury? If yes, what? _____

Any change in your thinking or behavior after the injury? _____

Ever have a neurological exam/genetic testing? _____ If yes, date and doctor? _____

What were the results of the neurological exam/genetic testing? _____

Have you had any of the following tests?

	<i>Date</i>	<i>Results</i>
1. EEG	_____	_____
2. CT scan	_____	_____
3. MRI	_____	_____
4. Other	_____	_____

Any exposure to toxic substances at work or elsewhere, e.g., carbon monoxide, lead, etc? _____

Handedness

Right _____ Left _____ Ambidextrous _____ What hand do you write with? _____

Mother's handedness _____ Father's handedness _____

Sibling(s) handedness _____

Legal History

Describe any trouble(s) you have had the law? _____

Further Information: _____

Name: _____

Lifestyle

Do you engage in physical exercise? _____ If yes, what _____

Do you take vitamins? If yes, what _____

What are your hobbies and interests? _____

Are you overwhelmed by job, school and/or family demands most days? _____

Is there an area of your life you would like to change? _____

Do you smoke cigarettes, pipe or cigars? _____ If yes, how much? _____

Report Distribution

Professionals/Individuals to receive report after you have reviewed it with Dr. Root and made changes as needed:

<i>Name</i>	<i>Address</i>	<i>Phone Number</i>
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____

Please Review and Sign I give Dr. Root permission to send the professionals and individuals listed above the neuropsychological assessment for a period of one year after the assessment is completed and to discuss with these professionals this assessment and the report. I understand that according to the federal laws of HIPPA no report can be sent out or shown to any professional until I have reviewed the report in detail and made changes as needed.

Signature

Date