Maitland Psychology, PA

ADULT INTAKE QUESTIONNAIRE

Name: _____ Date: _____/_____/_____

Name of person completing form and relationship to the patient:_____

Date of Birth: _____/_____/_____ Date of accident, injury, or onset of symptoms: _____/_____/_____

Marital Status: _____ Age: ____ Gender: □ M □ F Handedness: □ Left □ Right

Race/Ethnicity _____ Primary Language (if not English): _____

Referring Physician: _____ Primary Care Physician: _____

Medical Diagnoses (if any): _____

_____

Briefly describe your current concerns: _____

_____

_____

What specific questions would you like answered by this evaluation? _____

_____

Over the past six months my symptoms have: □ Improved □ Stayed the same □ Worsened

Are you experiencing any problems in the following aspect of your life? If so, please explain:

Marital/Family_____

Financial/Legal_____

Housekeeping/Money Management_____

Driving_____

Is there anything you (or someone else) can do that helps reduce the problem(s) or symptom(s)? If so, please describe: _____

_____

Is there anything that seems to make the symptom(s) or problem(s) worse? If so, please describe: _____

_____

Have others commented about changes in your thinking, behavior, personality, or mood? □ Yes □ No

If yes, who and what have they said? _____

_____

Are you currently receiving treatment addressing your concerns? If so, with whom and is it helpful: _____

_____

SYMPTOMS AND CONCERNS

Please check each symptom that applies and add any comments as needed.

Cognitive Concerns

Attention and Concentration

- □ Paying attention to things
- □ Maintaining concentration
- □ Losing my train of thought easily
- □ Difficulty doing more than one thing at a time
- □ Feeling less alert or aware of things
- □ Difficulty following instructions or directions
- □ Being distracted by my own thoughts
- □ Being distracted by noises or the environment
- □ Having my mind goes blank frequently
- □ Becoming easily confused and disoriented
- □ Tasks take more attention/effort than before
- □ Speed of thinking is slower than it used to be

Problem Solving and Organization

- □ Difficulty solving problems that others could manage
- □ Difficulty figuring out how to do new things
- □ Difficulty completing an activity in a reasonable time
- □ Difficulty doing things in the right order (sequencing)
- □ Difficulty organizing items for a project
- □ Difficulty problem-solving in social situations
- □ Difficulty changing a plan/activity as needed
- □ Difficulty planning ahead
- □ Difficulty thinking as quickly as needed

Word Finding and Naming

- □ Finding the word you want to say
- □ Forgetting names of family/close friends
- □ Difficulty learning new names
- □ Using the wrong words when speaking
- □ Forgetting names of acquaintances
- □ Difficulty getting my speech started

Speech and Language

- □ Difficulty understanding what others say
- □ Difficulty getting your speech started
- □ Change in the complexity of your speech
- □ Change in the speed of your speech
- □ Change in the clarity of your speech
- □ Change in volume of your speech

Memory

- □ Forget where I leave things (e.g., keys, phone, etc.)
- □ Forget why I walked into a room
- □ Forget things than happened hours or days ago
- □ Forget events that happened months or years ago
- □ Rely more on notes to remember things
- □ Forget facts but can remember how to do things
- □ Forget the content of conversation
- □ Getting lost while driving in familiar places
- □ Forget names
- □ Forget where I am or where I am going
- □ Forget appointments
- □ Rely more on others to remind me of things
- □ Forget how to do things
- □ Forget faces of people I know
- □ Forget if a conversation occurred
- □ Purchasing 6-7 items in a store without a list

Academic Skills

- □ Difficulty understanding what I read
- □ Difficulty retaining what I read
- □ Difficulty with spelling, grammar or punctuation
- □ Difficulty with mental math
- □ Difficulty with paper and pencil math
- □ Difficulty managing my finances

Physical Concerns

Sensory Symptoms

□ Please check if: □ Near-sighted □ Far-sighted □ Astigmatism
□ Blurred vision □ Difficulty with night vision □ Double vision
□ See things that are not there □ Poor peripheral vision □ Color blindness
□ Wear glasses: If so, since what age_____
□ Hearing loss □ Ringing in ears □ Hear strange sounds
□ Wear hearing aid: If so, since what age_____
□ Problems with taste: If so, Increased/Decreased sensitivity **(Please circle one)**
□ Problems with smell: If so, Increased/Decreased sensitivity **(Please circle one)**
□ Pain (Describe) _____

Motor Symptoms

□ Weakness on one side of body □ Tremor or shakiness □ Fine motor difficulties
□ Tic or strange movements □ Difficulty with balance □ Muscle stiffness
□ Muscle weakness □ Difficulty walking

Emotional and Behavioral Concerns

Mood/Behavior	**(PLEASE CIRCLE ONE IF APPLICABLE)**		
□ Sadness or depression	Mild	Moderate	Severe
□ Anxiety or nervousness	Mild	Moderate	Severe
□ Sleep problems	Falling asleep	Staying asleep	Both

ALCOHOL AND SUBSTANCE USE

I started drinking at age _____ Frequency of alcohol use:_____
Preferred types of drinks: _____ Usual number of drinks I have at a time: _____
My last drink was: □ < 24 hours ago □ 24-48 hours ago □ Over 48 hours ago
I used to drink alcohol but stopped. Date stopped: _____

Check all that apply:

□ I can drink more than most people my age and size before I get drunk.
□ I sometimes get into trouble (fights, legal difficulty, work problems, conflicts with family, accidents, etc.) after drinking. Please specify:_____
□ I sometimes have the following personality changes when drinking: _____
_____
□ I sometimes black out after drinking. □ I have been dependent on alcohol.
□ I have gone through drug withdrawal. □ I have used IV drugs.
□ I have been in drug treatment.
Do you smoke cigarettes currently? □ Yes □ No If yes, amount per day: _____
I used to smoke cigarettes, but stopped. Please list ages and amount per day:_____
Please specify the type and amount of caffeinated beverages consumed per day (if applicable):
_____

Please check all the drugs you are now using or have used in the past:

	Presently Using	Used in Past
Amphetamines (including diet pills)	□	□
Barbituates (Downers, etc.)	□	□
Cocaine or Crack	□	□
Hallucinogenics (LSD, Acid, STP, etc.)	□	□
Inhalants (Glue, Nitrous Oxide, etc.)	□	□
Marijuana	□	□
Opiate narcotics (Heroin, Morphine, etc.)	□	□
PCP (Angel Dust)	□	□
Others (list)	□	□

Frequency of drug use and amount used: _____

_____

Do you consider yourself dependent on any drugs? □ Yes □ No □ Previously/Not Currently
If yes, which ones? _____
Do you consider yourself dependent on any prescription drugs? □ Yes □ No □ Previously/Not Currently
If yes, which ones? _____

PSYCHOSOCIAL HISTORY

You were born: □ On time □ Prematurely □ Late
You were born through: □ Vaginal Delivery □ A Caesarean section
Were there any problems associated with your birth or early infancy? □ Yes □ No
If yes, please describe:_____

Please check all that applied to your mother while she was pregnant with you:

□ Accident □ Alcohol use
□ Cigarette smoking □ Drug use (marijuana, cocaine, LSD, etc.)
□ Poor nutrition □ Psychological problems
□ Medications (prescribed or over the counter) taken during pregnancy
□ Illness (toxemia, diabetes, high blood pressure, infection, etc.)

Please select the approximate time of the following developmental milestones:

	Early	On Time/Average	Late
Walking	□	□	□
Language	□	□	□
Toilet training	□	□	□

As a child, did you have any of these conditions:

□ Attention problems □ Learning disability □ Speech problems
□ Developmental delay □ Hearing problems □ Visual problems
□ Hyperactivity/Impulsivity □ Frequent ear infections □ Asthma
□ Acting Out Behaviors □ Social difficulties □ Oppositional Behavior

FAMILY HISTORY

The following questions are about your family of origin:

Who lived in the household when you were growing up? _____

Is your mother alive? □ Yes □ No If deceased, what was the cause of her death?_____

Is your father alive? □ Yes □ No If deceased, what was the cause of his death? _____

Did your parents ever separate or divorce? □ Yes □ No If yes, how old were you? _____

Was there any abuse or neglect in the home growing up? □ Yes □ No

Did you have any step-parent(s)? □ Yes □ No Were you adopted? □ Yes □ No

Name of Sibling(s)	Age	Gender	Full, Half, Step, or Adopted	Where do they live?

Were there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters? □ Yes □ No If yes, describe: _____

RELATIONSHIP HISTORY

Sexual Identity: □ Heterosexual □ Homosexual □ Bisexual □ Transgender

Name of spouse/partner	Years together	# of pregnancies	# of children	Divorce Date	Date of death	Any abuse?	
						Yes	No
						Yes	No
						Yes	No
						Yes	No

Name of Child	Gender	Age	Where does your child live?	Date last spoken to

Who currently lives at home with you?_____

Do any family members have significant health concerns/special needs? _____

_____

Please check the issues that have affected biological family members and list the relationship:

Neurologic disease	**Family Member Affected**
□ Alzheimer's disease or dementia	_____
□ Huntington's disease	_____
□ Multiple Sclerosis	_____
□ Parkinson's disease	_____
□ Epilepsy or seizures	_____
□ Other neurologic disease	_____
Psychiatric Illness	
□ Depression	_____
□ Anxiety	_____
□ Bipolar illness (Manic-Depression)	_____
□ Schizophrenia	_____
□ Other (Please Specify)_____	_____
_____	_____
Other Disorders	
□ Autism/Asperger's syndrome	_____
□ Intellectual Disability	_____
□ Speech or language disorder	_____
□ Learning problems	_____
□ Attention problems	_____
□ Behavior problems	_____
□ Other (Please specify) _____	_____
_____	_____

EDUCATIONAL HISTORY

Highest level of education completed: _____

If attended high school, where? _____ If attended college, where?_____

If a high school diploma was not awarded did you complete a GED? □ Yes □ No

Were any grades repeated? □ Yes □ No If yes, why? _____

Did you have any problems learning to read, write, or do math? _____

Did you have any problems with attention, hyperactivity, and/or impulsivity? □ Yes □ No

Were you ever in any special classes or did you ever receive special services? □ Yes □ No

If yes, what grades or age? _____ What type of class? _____

What were your grades typically like in school? □ A & B □ B & C □ C & D □ D & F

Provide any additional helpful comments about your academic performance: _____

_____

_____

OCCUPATIONAL HISTORY

Are you currently working? □ Yes □ No
Current job title: _____ Dates of employment: _____ to _____
Do you see your current work situation as stable? □ Yes □ No
Current responsibilities: _____
Are you currently experiencing any problems at work? □ Yes □ No
If yes, describe: _____

Previous employers:

Position	Dates	Reason for leaving
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MILITARY SERVICE

Did you serve in the military? □ Yes □ No If yes, which branch and dates?_____
Did you ever see combat? □ Yes □ No Were you honorably discharged? □ Yes □ No
Did you receive injuries or were you exposed to any dangerous or unusual substances during your service?
□ Yes □ No If yes, explain: _____
Do you have any continuing emotional, mental, or physical problems related to your military service? □ Yes
□ No If yes, explain:_____

RECREATION

Briefly list the types of recreational activities that you enjoy (e.g., games, TV, hobbies, sports, etc.): _____
_____
Are you still able to do these activities? _____
If not, why not? _____

MEDICAL AND TREATMENT HISTORY

Which physician(s) are most familiar with your current condition: _____
_____
Date of last vision exam and results: _____
Date of last hearing exam and results: _____

Please list any significant childhood illnesses, fevers, or injuries _____
_____
_____

Please check any symptoms that you currently have, or have had in the past:

☐ Head injury or concussion	☐ Migraine headaches
☐ Loss of consciousness from a head injury	☐ Aura prior to a migraine headache
☐ Broken bones from a traumatic event	☐ Sensitivity to light or sound with a headache
☐ Back or Neck Injury	☐ Nausea or vomiting
☐ Excessive fatigue	☐ Sinus headaches
☐ Numbness or tingling	☐ Tension headaches
☐ Food or medication allergies	☐ Dizziness or Vertigo
☐ Exposure to toxins or chemicals	☐ Exposure to toxins or chemicals
☐ Heart Disease	☐ Diabetes
☐ Seizures	☐ Stroke

Please describe any significant injuries or illnesses experienced as an adult: _____

_____

_____

Please list any allergies _____

Please list any surgeries you have had:

Surgery	Month & Year	Results/Success?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current medical/psychiatric problems and medications taken for each problem (if any)

Medication & Dosage	Frequency Taken	Medical Problem
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a prior psychological or neuropsychological exam? □ Yes □ No

If yes, please complete the following:

Name of psychologist: _____

Date of exam: _____

Reason for evaluation:_____

Findings of evaluation:_____

Please check off and describe any of the applicable neuroimaging and tests:

Test	Date	Abnormal Findings
□ Blood work	_____	_____
□ CT Scan	_____	_____
□ MRI	_____	_____
□ PET Scan	_____	_____
□ SPECT Scan	_____	_____
□ Skull X-Ray	_____	_____
□ EEG	_____	_____
□ Neurological exam	_____	_____
□ Other	_____	_____

Are you currently in counseling or under psychiatric care? □ Yes □ No

If yes, please list the date therapy was initiated and names of professionals treating you:_____

_____

Please list any previous counseling and other mental health treatment with reason and duration: _____

_____

_____

Please list all medical and psychiatric hospitalizations:

Name of Hospital Date of hospitalization Length of stay Diagnosis

_____

_____

_____

_____

Please provide any additional information that you feel is relevant to this referral:

_____

_____

_____

_____

Please bring this form with you to your first appointment. All information disclosed is part of your psychological records and thus confidential, as dictated by the Health Insurance Portability and Accountability Act, and the rules and regulations from the State of Florida.