ACHIEVE! CENTER, INC.

Adult

Client_____ DOB_____ Gender ☐ male ☐ female

(first) (MI) (last)

Mailing address_____ City_____State_____ Zip _____

Marital Status S M D W Employer_____

Telephone Home_____ Work_____ Cell_____

May we contact you at home? ☐ yes ☐ no At work? ☐ yes ☐ no On your cell? ☐ yes ☐ no

Person financially responsible_____ Social Security Number_____

Relationship to client_____ Home phone_____

Address_____ City_____State_____ Zip_____

Employer_____ Business phone_____

Referral source_____

Emergency contact_____ Phone_____

Family physician/clinic_____

INSURANCE INFORMATION

Primary insurance name_____

Policyholder name_____ Policyholder DOB_____

Policy number_____ Group #_____ Insurance Phone #_____

***Social Security Number of client**_____

Secondary insurance name_____

Policyholder name_____ Policyholder DOB_____

Policy number_____ Group #_____ Insurance Phone #_____

****As of January 1, 2010 your social security number is required by insurance providers.***

ADULT INTAKE QUESTIONNAIRE

Please fill out this form as completely as possible. The information you provide is confidential and protected by law.

Date: _____

Demographic Information
Name: _____ Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Who referred you? _____
_____

What questions do you hope will be answered? _____
_____
_____

What concerns bring you here?

☐ Irresponsible	☐ Employment	☐ Marriage/family	☐ Mood problems
☐ Problems with mobility	☐ Physical pain/injury	☐ Inadequate energy	☐ Anxiety
☐ Problems with speech	☐ Social relationships	☐ Memory problems	☐ Anger
☐ Recognition of danger	☐ Sleep problem	☐ Learning problems	☐ Grief
☐ Money management	☐ Appetite problem	☐ Cognitive problems	

DEVELOPMENTAL HISTORY
Mother's age at time of your birth: _____ **Father's age at time of your birth:** _____

What were the complications or concerns during your pregnancy for your mother? ☐ None
(If any of the following occurred, please elaborate on condition/treatment.)
☐ Gestational diabetes ☐ Anemia ☐ Preeclampsia ☐ Placenta previa ☐ Toxemia ☐ Depression
☐ Sexually transmitted disease ☐ Heart disease ☐ Physical trauma ☐ Other: _____

Length of Pregnancy
☐ Full term ☐ Premature – born at how many weeks? _____

Was labor induced? ☐ No ☐ Yes, please describe the reason: _____

Mode of delivery: ☐ Vaginal ☐ Cesarean ☐ Emergency Cesarean

Were there any concerns or complications during/immediately following your delivery?
☐ Baby's heart rate dropped ☐ Cord wrapped around neck/nuchal cord
☐ Born "blue" ☐ Breech
☐ Low Apgar scores ☐ Significant jaundice (bilirubin)
☐ Treatment in the NICU – details: _____

Temperament as an infant: ☐ Easy ☐ Withdrawn ☐ Difficult ☐ Other: _____

Bonding: ☐ Cuddly ☐ Withdrawn ☐ Clingy ☐ Other: _____

Activity level as an infant: ☐ Average ☐ On-the-go ☐ Destructive ☐ Lethargic ☐ Accident prone

Apprehension with strangers: ☐ Mild ☐ Moderate ☐ Severe ☐ None

Emotionally oversensitive/over-reactive as an infant: ☐ No ☐ Yes
Does this continue to be a problem? ☐ No ☐ Yes

Developmental milestones (check all that apply if you know):

12 Months:

☐ Pulls to stand and may take a few steps alone
☐ Says 2-4 words, imitates vocalizations
☐ Waves "bye-bye"
☐ Looks for dropped or hidden objects
☐ Feeds self
☐ Drinks from cup

18 Months:

☐ Walks backward
☐ Uses two-word phrases
☐ Follows simple directions
☐ Throws ball
☐ Uses a spoon and cup
☐ Points to some body parts
☐ Scribbles
☐ Shows affection, kisses
☐ Pulls a toy along the ground

24 Months:

☐ Goes up and down stairs one step at a time
☐ Stacks five blocks
☐ Follows two-step commands
☐ Uses at least 20 words, two-word phrases
☐ Imitates adults
☐ Kicks ball

5 Years:

☐ Dresses self without help
☐ Can count on fingers
☐ Recognizes most letters and print some
☐ Learns address/phone number
☐ Copies basic shapes

11-21 Years:

☐ Sexual development
☐ Peer relationships
☐ Social/emotional interaction
☐ Worries about grades

MEDICAL HISTORY

Date of last physical examination: _____

Purpose of physical examination: _____

_____

Name of primary care physician & clinic name: _____

☐ **Major Surgery** (attach additional information/list if needed):

Procedure: _____ Procedure: _____

_____ _____

Age: _____ Age: _____

☐ No complications ☐ No complications

Complications: _____ Complications: _____

_____ _____

☐ **Medical Hospitalization** (attach additional information/list if needed):

Cause: _____ Cause: _____

_____ _____

_____ _____

Dates/Age: _____ Dates/Age: _____

☐ **Medical Diagnoses:**

1.	3.	5.
2.	4.	6.

As a child did you ever experience the following? If yes, please elaborate.

☐ High fever requiring hospitalization or treatment: _____

☐ Unexplained fever or spike of temperature: _____

☐ Head injury: _____

☐ Concussion: _____

☐ Loss of consciousness: _____

☐ Seizures Type: ☐ Partial ☐ Partial complex ☐ Generalized

Beginning at what age: _____ Frequency: _____

☐ Tics – please describe: _____

☐ Thyroid or endocrine problems

☐ Chronic ear/sinus infections Were tubes required? ☐ No ☐ Yes, at what age(s): _____

☐ Chronic allergies ☐ Diabetes/blood sugar problems ☐ Meningitis, encephalitis

☐ Bronchitis, pneumonia ☐ Upper respiratory problems/asthma

☐ Other congenital conditions: _____

Please list currently prescribed medications:

	Medication	Dose	Frequency	Prescribing Physician
1.				
2.				
3.				
4.				
5.				

Past medications that have produced a negative reaction/ineffective medications:

	Medication	Reason for Discontinuation
1.		
2.		
3.		
4.		
5.		

Current Medical Conditions/Illnesses

Hearing: ☐ No problems ☐ Conductive impairment ☐ Sensori-neural impairment ☐ Hearing devices

Vision: ☐ No problem ☐ Nearsighted ☐ Farsighted ☐ Glasses ☐ Contacts ☐ Blind ☐ Other: _____

Current Sleep

☐ Duration in hours: _____ ☐ Requires naps ☐ Midnight awakening ☐ Early awakening

☐ Difficulty falling asleep ☐ Other: _____

☐ Nightmares ☐ Frequency: _____ per week ☐ Content:: _____

Appetite

☐ No problems ☐ Obsessed with food – since: _____ ☐ Increased/decreased appetite—since: _____

☐ Weight gain/loss ☐ Amount in pounds: _____ Since: _____

PSYCHIATRIC HISTORY

☐ **Psychiatric hospitalization** Where: _____

Cause:_____ Cause: _____

_____ _____

Dates/Age: _____ Dates/Age: _____

Have you been diagnosed previously with any type of developmental diagnosis? (Please circle applicable diagnosis.)

ADHD/ADD

When was the diagnosis made? _____

Autistic spectrum disorder (autism, Asperger's syndrome, PDD.NOS)

When was the diagnosis made? _____

Cognitive impairment / mild / moderate / severe mental retardation

When was the diagnosis made? _____

Receptive / expressive / mixed speech delay

When was the diagnosis made? _____

Learning Disability

When was the diagnosis made? _____

Other / psychiatric diagnoses

What was/were the diagnosis(es)? _____

Ever treated by a mental health professional(s)? ☐ Yes ☐ No

	Name of Professional	Time Frame/Dates of Treatment
Psychologist(s):		
Psychiatrist(s):		
Neurologist(s):		
Therapist(s):		

Current mental health professional(s)? ☐ Yes ☐ No

	Name of Professional	Time Frame/Dates of Treatment
Psychologist(s):	_____	_____
Psychiatrist(s):	_____	_____
Neurologist(s):	_____	_____
Therapist(s):	_____	_____

Are you currently experiencing any of the following?

Nearly Daily	Sometimes	Not Really	
_____	_____	_____	Trouble remembering things
_____	_____	_____	Spells of sudden fear that did not make sense
_____	_____	_____	Trouble doing your job or schoolwork
_____	_____	_____	Thoughts of dying
_____	_____	_____	Someone thinks you drink to much
_____	_____	_____	Being in too many arguments
_____	_____	_____	Avoiding things/places most people do not avoid
_____	_____	_____	Being in trouble
_____	_____	_____	Feeling keyed up or on the edge
_____	_____	_____	Having peculiar thoughts
_____	_____	_____	Difficulties with sexual matters
_____	_____	_____	Increased stress in your life
_____	_____	_____	Worry
_____	_____	_____	Feelings of guilt
_____	_____	_____	Sad mood
_____	_____	_____	Irritability, easily annoyed
_____	_____	_____	Poor concentration
_____	_____	_____	Sleep problems
_____	_____	_____	Low energy
_____	_____	_____	Headaches
_____	_____	_____	Shortness of breath, chest pains
_____	_____	_____	Dizziness, numbness
_____	_____	_____	Trembling
_____	_____	_____	Pains
_____	_____	_____	Loss of appetite
_____	_____	_____	Overeating
_____	_____	_____	Other: _____

SUBSTANCE ABUSE

Please indicate any substance used currently or in the past and effects:

Current	Past				
☐	☐	Alcohol	☐ Blackouts	☐ Sweats	☐ Rage
☐	☐	Marijuana	☐ Cravings	☐ Pass out	☐ Depressed mood
☐	☐	Cocaine	☐ Nausea	☐ Paranoia	☐ Hyper
☐	☐	Heroin	☐ Dizziness	☐ Lethargy	☐ Extreme thirst
☐	☐	Ecstasy	☐ Trembling	☐ Slurred speech	☐ Unstable gait
☐	☐	Huffing (gas, aerosol, etc.)			
☐	☐	Other: _____			

Please indicate the word(s) that best describe your alcohol or drug use:

☐ Experimental ☐ Recreational ☐ Abusive ☐ Dependent ☐ Minimal ☐ Destructive

Have you ever attended a substance abuse treatment program? ☐ No ☐ Yes, dates: _____

Where: _____

FAMILY OF ORIGIN Please list all living and deceased.

	Name	Age	Occupation/School	Lives with child
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Stepsiblings				

How would you describe your relationship with your parent and siblings while growing up?

_____

_____

Now? _____

_____

If parents divorced, describe child placement: _____

_____

FAMILY

Current Living Situation/Marital Status

☐ Never married, living in:	☐ own home	☐ rented apartment	☐ other: _____
☐ Legally married, living in:	☐ own home	☐ rented apartment	☐ other: _____
☐ Unmarried—committed relationship, living in:	☐ own home	☐ rented apartment	☐ other: _____
☐ Divorced, living in:	☐ own home	☐ rented apartment	☐ other: _____
☐ Separated, living in:	☐ own home	☐ rented apartment	☐ other: _____

MARRIAGE AND FAMILY

Date of marriage: _____

Date of divorce: _____

Date(s) of previous marriage(s): _____

Date(s) of previous divorce(s): _____

Name of spouse/significant other: _____

Age: _____ DOB: _____ Dates of previous marriage: _____ Divorce: _____

Name of employer: _____ Job title: _____

Names of your children:

Biological, Step, or Adopted	DOB	School Level/Occupation

How would you describe your relationship with your spouse/significant other?_____

_____

How would you describe your relationship with your children? _____

_____

Persons living in the home:

Name	Age	Nature of Relationship to You	Quality of Relationship
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor

Other important persons in your life:

Name	Age	Nature of Relationship to You	Quality of Relationship
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor

Paternal (biological father's) Family History

☐ ADHD, ADD, impulsivity
☐ Autistic spectrum disorders
☐ Learning disorder, learning problems
☐ Depression
☐ Anxiety, panic attacks
☐ Bipolar disorder ("manic-depression")
☐ Alcohol/drug abuse
☐ Schizophrenia or other psychotic/delusional disorders
☐ Cardiopulmonary difficulties
☐ Specific genetic problem: _____
☐ Specific neurological disorder: _____
☐ Other: _____

Maternal (biological mother's) Family History

☐ ADHD, ADD, impulsivity
☐ Autistic spectrum disorders
☐ Learning disorder, learning problems
☐ Depression
☐ Anxiety, panic attacks
☐ Bipolar disorder ("manic-depression")
☐ Alcohol/drug abuse
☐ Schizophrenia or other psychotic/delusional disorders
☐ Cardiopulmonary difficulties
☐ Specific genetic problem: _____
☐ Specific neurological disorder: _____
☐ Other: _____

Significant Trauma (include age at time of incident, nature of trauma, and any legal details)

☐ Injured in an accident: _____
☐ Physical abuse (☐ victim ☐ perpetrator): _____
☐ Sexual assault/abuse (☐ victim ☐ perpetrator): _____
☐ Emotional abuse (☐ victim ☐ perpetrator): _____
☐ Neglect: _____

LEGAL

Please detail any contacts (including dates and outcomes) you have had with the courts, police, etc.:

_____
_____

EMPLOYMENT

Have you ever been employed? ☐ Yes ☐ No
Were you ever fired? ☐ No ☐ Yes – details: _____
Current job status: ☐ Full-time ☐ Part-time ☐ Disabled ☐ Laid off ☐ Retired ☐ Other: _____

Jobs held:

Employer	Dates	Job Title	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Financial status: ☐ Stable ☐ Unstable: _____

Military Service: ☐ No ☐ Yes Dates: _____ Discharge: _____
☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard
☐ Reserves: _____ ☐ National Guard: _____

PERSONAL INFORMATION
What are your greatest strengths/attributes? _____
_____

Hobbies/Interests

	Recent change in frequency?		
_____	☐ No change	☐ Decreased	☐ Increased
_____	☐ No change	☐ Decreased	☐ Increased
_____	☐ No change	☐ Decreased	☐ Increased

ACADEMIC
Started school at age: _____ Highest grade completed: _____ Age: _____

Did you utilize Special Education support services? ☐ No ☐ Yes
Please specify below all classifications that have been used, and *circle any current classification*.
☐ Cognitively impaired ☐ Emotionally impaired ☐ Hearing impaired ☐ Visually impaired
☐ Other health impairment ☐ Severe multiple impairment ☐ Speech and language impairment
☐ Learning disabled: _____
Academic Performance:
☐ Consistently A's, B's ☐ Consistently B's, C's
☐ Consistently C's, D's ☐ Consistently C's, D's
☐ Dropped out of school (at age: _____, grade: _____)
☐ Graduated from high school ☐ Obtained GED ☐ Regular diploma ☐ Special education certificate
☐ College name, degree, and major: _____

As a child were you ever:
☐ Held back – What grades? _____
☐ Suspended – For what and for how long? _____
☐ Expelled – From what grade and why? _____
☐ Home schooled – When and why? _____

Additional information you would like to let the clinician know:
_____
_____
_____
_____

Completed by: _____ **Date:** _____