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.***

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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
- ☐ Drinks from cup
- ☐ Says 2-4 words, imitates vocalizations
- ☐ Looks for dropped or hidden objects
- ☐ Waves "bye-bye"
- ☐ Feeds self

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

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

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

11-21 Years:
- ☐ Sexual development
- ☐ Worries about grades
- ☐ Peer relationships
- ☐ Social/emotional interaction

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**

Cause: ________________

Dates/Age: ________________

Where: ________________

Cause: ________________

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: ______________________

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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:** ____________

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