Adult Extended Intake Information Form

General Information

Client

- Name: _____Today's Date:_____ Age:_____ Gender:_____
- Date of birth:_____ Place of birth: _____
- Home Address:_____ City:_____
- Zip Code:_____ Home phone: ( )_____ cell: ( )_____
- e-mail address: _____ Referred by: _____
- Check the box for the racial or ethnic group with which you identify:

  ❑ Caucasian ❑ African American ❑ Hispanic ❑ Asian/Asian American

  ❑ Native American ❑ Other:_____
- What culture do you identify with? _____

Emergency

- In case of emergency, please call: _____ Telephone: ( ) _____

→ **I have received and agree with the informed consent:** ❑ **No** ❑ **Yes**

Consultant Information

- **Physician**

  Name:_____ Address:_____

  City:_____ Zip:_____ Phone: ( )_____

- **Other Professionals**

  Type of Service:_____

  Name:_____ Address:_____

  City:_____ Zip:_____ Phone: ( )_____

  Type of Service:_____

  Name:_____ Address:_____

City:_____ Zip:_____ Phone: ( )_____

Current Living Situation

Living Arrangement

- With whom do you live?

  ❑ Parents ❑ Present family (spouse/children) ❑ With partner ❑ Alone ❑ Roommates

  ❑ Other:_____

- Problems with current living arrangement: ❑ Yes ❑ No If yes, specify: _____

  _____

Family of Descent

- Marital status: ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

  If married:

  Spouse Name: _____ Age: _____

  Name and ages of children:

  1. _____ Age: _____
  2. _____ Age: _____
  3. _____ Age: _____
  4. _____ Age: _____

- Problems with family of descent: ❑ Yes ❑ No If yes, specify:_____

  _____

Occupation

- Title:_____
- Business Name:_____
- Business Address:_____ City:_____
- Zip Code:_____ Work phone: ( )_____
- Duties: _____
- Annual Family Income: $_____
- Problems with occupational life: ❑ Yes ❑ No If yes, specify:_____

  _____

→ **Please attach a resume, or CV, with this intake form.**

Family Background

Parents

- Mother's Name: _____
- Mother's Education Level: _____ Occupation: _____
- Give a description of your mother's personality: _____

  _____

  _____

- Father's Name: _____
- Father's Education Level: _____ Occupation: _____
- Give a description of your father's personality: _____

  _____

  _____

- If parents are separated or divorced: Date:_____ Your age:_____

  Your reaction: _____
- Is a parent deceased? ❑ No ❑ Yes If yes, please specify: _____
- Are you adopted ? ❑ No ❑ Yes Guardianship as a child? ❑ No ❑ Yes
- Are you satisfied with your family relationships? ❑ No ❑ Yes
- Are there any family problems that you feel might be contributing to your difficulties?

  ❑ No ❑ Yes If yes, please describe:_____

Siblings

- Please list all siblings (including step-siblings), current ages, gender, and a brief description of your relationship with them.

  1._____

  2._____

  3._____

  4._____

  5._____

Family Relationships

- Please describe your relationship with your:

  Mother: _____

  Father: _____

Siblings: _____

Others: _____

- Please describe the parenting styles of each parent:

  _____

  _____

- How did your parents handle discipline issues? _____

  _____

- What were the most difficult behaviors for your parents to handle? _____

  _____

- How much supervision did you need compared to peers? ❑ More ❑ Same ❑ Less

Developmental History

Pregnancy

- Mother's overall health during pregnancy: _____

  _____

- Was mother exposed to any infectious diseases (e.g., rubella, syphilis, AIDS, toxoplasmosis) during the pregnancy? ❑ No ❑ Yes
- Medications used by <u>mother</u> during pregnancy:
  ❑ None
  ❑ Prescription medications,
  Name:_____
  ❑ Non-prescription medications,
  Name:_____
  ❑ Caffeine ❑ Tobacco ❑ Alcohol ❑Other:_____
- Mother's diet during pregnancy: ❑ Good ❑ Average ❑ Poor
- Did mother take daily vitamins during her pregnancy? ❑ No ❑ Yes
- Medications used by <u>father</u> 6 months prior to pregnancy:
  ❑ None
  ❑ Prescription medications,
  Name:_____
  ❑ Non-prescription medications,
  Name:_____
  ❑ Caffeine ❑ Tobacco ❑ Alcohol ❑Other:_____
- Father's diet prior to pregnancy: ❑ Good ❑ Average ❑ Poor
- Was the father's exposed to high amounts of toxicities such as radiation, lead, or pesticides prior to pregnancy? ❑ No ❑ Yes

Birth

- Mother's age at delivery: _____ Any labor or birth complications: _____

  _____

  APGAR Scores (if known) : 1 min. _____ 5 mins. _____ 10 mins._____

  ❑ Premature, weeks early:_____ ❑On Time ❑ Late, weeks late: _____

  ❑ Evidence of fetal distress:_____

- Birth weight: _____
- Were you taken away following delivery? ❑ No ❑ Yes
- Were you allowed to nurse following delivery? ❑ No ❑ Yes
- Father's age at delivery: _____

Sensory Functioning

- Are you aware of any problems you have processing sensory information (e.g., visual, auditory, touch, taste, smell)? If yes, please explain: _____

  _____

- Do you have synesthesia? ❑ No ❑ Yes. Synesthesia is the involuntary stimulation of one sensory modality reliably causes a perception in one or more different senses? For example, letter/numbers may have colors (e.g., the letter "A" may be red), a person might describe the color, shape, and flavor of someone's voice, music has a shape to it, or a scent is associated with a color.

- Are you "hypersensitive" to, or does it cause you undue stress/anxiety, when you encounter:
  ❑ light touch ❑ sudden movement ❑ high frequency noises
  ❑ excessive noise ❑ excess of visual stimuli ❑ certain smells
  ❑ certain foods/tastes

Early Development

- Did you "nestle"? ❑ No ❑ Yes
- Did you prefer separate space to being held? ❑ No ❑ Yes
- Did you prefer to be tightly wrapped or "swaddled"? ❑ No ❑ Yes
- Were your cries soothed when: …fed? ❑ No ❑ Yes …held?❑ No ❑ Yes

  …changed? ❑ No ❑ Yes…bathed? ❑ No ❑ Yes …rocked? ❑ No ❑ Yes
- Were you breast fed? ❑ No ❑ Yes
- Were there *feeding problems*? If yes, please describe:_____

- Did you sleep in a separate crib? ❑ No ❑ Yes
- Was the crib in the same room with your mother? ❑ No ❑ Yes
- What was your *general temperament* during the early years?
  ❑ Easy, adaptable ❑ Withdrawn, slow to adapt ❑Difficult, intense reactions ❑ Colicky
- Did you attach to the primary caretaker? ❑ No ❑ Yes
- Who was the primary caretaker? _____
- Would you consider the *early attachment* between you and your mother:
  ❑ Strong ❑ Moderate ❑ Weak
- How would you describe your early *sleeping patterns?*
  ❑ Regular and predictable ❑ Irregular and unpredictable
  ❑ Required very little sleep ❑ Required much sleep
- How would you describe your early *feeding patterns?*
  ❑ Regular and predictable ❑ Irregular and unpredictable
  ❑ Required little food ❑ Required much food
- What was your early *general activity level?*
  ❑Hyperactive ❑ Active ❑ Average ❑ Low energy ❑ Lethargic
- In general, were you: ❑ Easy to care for ❑ Difficult to care for
- How did you respond to *changes in routine* or to *transitions*?
  ❑ Easy, adaptable ❑ Withdrawn, slow to adapt ❑Difficult ❑Crying/Screaming
- Did *toilet training* present any difficulties? ❑ No ❑ Yes If yes, please describe:
  _____
- Were you exposed to *physical abuse*? ❑ No ❑ Yes
- Were you exposed to *emotional abuse*? ❑ No ❑ Yes
- Were you exposed to *sexual abuse*? ❑ No ❑ Yes
- Were you exposed to any traumatic events? ❑ No ❑ Yes, what: _____
  _____
- Please describe any other *significant events* during your early years (e.g., postpartum depression, illness, trauma, moves, marital difficulties) and their impact on this student:
  _____
  _____

Language Development

- During the first year of life, other than crying, would you say that you were a:
  ❑ Silent or very quiet baby ❑ Very noisy baby ❑ Verbally interactive baby
- How was your language development? ❑ Consistent ❑ With significant breaks
- First spoken words: ❑ Early ❑ Typical ❑ Late
- First spoken sentences: ❑ Early ❑ Typical ❑ Late
- Did you have any trouble:
  Making certain speech sounds? ❑ No ❑ Yes
  Understanding language? ❑ No ❑ Yes

Describing events and/or telling a story coherently? ❑ No ❑ Yes

Hearing subtle differences in words (e.g., pin/pen)? ❑ No ❑ Yes

- Overall, you feel that your language development was:
  ❑ Slower than peers ❑ About the same as peers ❑ Ahead of peers
- Your primary language: ❑ English ❑ Other: _____
- Languages spoken in the home: ❑ English ❑ Other: _____

Motor Development

- Sitting alone: ❑ Early ❑ Typical ❑ Late
- Crawling: ❑ Early ❑ Typical ❑ Late
- Standing alone: ❑ Early ❑ Typical ❑ Late
- Walking alone: ❑ Early ❑ Typical ❑ Late
- Any difficulties with *gross motor tasks*, e.g. balancing, hopping, running? ❑ No ❑ Yes
- Any concerns with your *fine motor* abilities, e.g. cutting, writing, eating? ❑ No ❑ Yes
- Overall, you feel that your motor development was:
  ❑ Slower than peers ❑ About the same as peers ❑ Ahead of peers

Medical History

- Date of last physical: _____
- Please describe your current health: _____
  _____
- Do you have any health problems that need to be addressed? _____
  _____
- Hearing: ❑Normal ❑Below average ❑Wear aid Date of last check: _____
- Vision: ❑Normal ❑Below average ❑Wear glasses Date of last check: _____
- Do you have a regular sleep schedule (e.g., pretty much 11pm to 7am nightly)? ❑ No ❑ Yes
- Do you have any problems falling or staying asleep? If yes, explain: _____
  _____
- Have you ever participated in a sleep study? ❑ No ❑ Yes If yes, explain: _____
  _____

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This information will remain strictly confidential, but it is very important for me to know before you begin so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

Current	Past	Type	Frequency/Comments
❑	❑		
❑	❑		
❑	❑		
❑	❑		
❑	❑		
❑	❑		
❑	❑		
❑	❑		
❑	❑		
❑	❑		
❑	❑		

- Are you attracted to stimulants (e.g., caffeine, cocaine)? ❑ No ❑ Yes
- How many cups of coffee, tea, caffeinated sodas do you drink a day? _____
- Do you have frequent physical complaints such as stomachaches or headaches that may be related to stress or tension? ❑ No ❑ Yes
- Do you smoke? ❑ No ❑ Yes, frequency: _____
- Do you drink alcohol? ❑ No ❑ Yes, frequency: _____
- What happens to you when you consume alcohol? _____

  _____

- Have you ever suffered from any of the following? *(check all that apply)*

Condition:	When?	Comments:
❑ Accidents		
❑ Allergies		
❑ Asthma		
❑ Ear infections		
❑ Head Injuries		
❑ Hospitalizations		
❑ Neurological sx's		
❑ Other Injuries		
❑ Seizures		

❑ Thyroid Problems		
❑ Tics		
❑ Other		

Eating Checklist

- Do you have a regular eating schedule (e.g., pretty much 3 balanced meals per day)?
  ❑ No ❑ Yes
- Describe your diet and any problems with eating_____
  _____

- Do you have any problems with eating? If yes, explain:_____
  _____

Yes	No	Question
❑	❑	Do you feel society pressures you to be thin?
❑	❑	Do you believe you're preoccupied with food?
❑	❑	Do you feel guilty about eating?
❑	❑	Do you feel you need to be perfect when it comes to weight control?
❑	❑	Do you feel that your weight is one of the few aspects of your life you can control?
❑	❑	Do you diet excessively and/or abuse laxatives, diet pills or diuretics?
❑	❑	Do you feel isolated from your family?
❑	❑	Do you ever consume large amounts of food in a frenzy of hunger?
❑	❑	Do you induce vomiting after eating, particularly after a binge?
❑	❑	Do you exercise excessively in an effort to control weight?
❑	❑	Do you feel fat even though others tell you that you are thin?
❑	❑	Does your weight fluctuate dramatically?

Mental Health History

- Please list any current psychological symptoms or emotional difficulties:_____
  _____
  _____

- Please list any past psychological complaints:_____
  _____
  _____

- Have you ever been hospitalized for a mental health reason? ❑ No ❑ Yes

- Please list any previous outpatient mental health treatment/therapy experience: _____
  _____
  _____

Electronic Entertainment Usage

- How many hours per day do you spend on electronic entertainment such as the Web browsing, Facebook, U-tube, computer/videogaming, and texting? _____
- Do you feel that your use of electronic entertainment is balanced and healthy?
  ❑ Yes ❑ No, please explain: _____

  _____

Attentional Checklist (Please check all statements that apply to you)

Inattention

As a child	Now	Behavior
❑	❑	I often fail to give close attention to details and make careless mistakes.
❑	❑	I often have difficulty sustaining attention in tasks.
❑	❑	I often do not seem to listen when spoken to directly.
❑	❑	I often do not follow through on instructions and fail to finish tasks.
❑	❑	I often jump from one task to another.
❑	❑	I have difficulty getting organized.
❑	❑	I avoid and dislike tasks that require sustained mental effort.
❑	❑	I often lose things necessary for tasks or activities.
❑	❑	I am often distracted by noises outside (e.g., birds, voices next door, cars).
❑	❑	I am often forgetful in daily activities.
❑	❑	I have a tendency to tune out or drift away in conversations.
❑	❑	I find myself needing to reread a paragraph or page due to daydreaming.
❑	❑	I find it's important to "multitask" to keep focused on certain tasks (rapid shifting of attention from one task to another; doing several things at once).
❑	❑	I space out frequently.

Hyperactivity

As a child	Now	Behavior
❑	❑	I exhibit restlessness (fidget, squirm, shake leg, tap feet, pace, doodle).

❑	❑	Compared to peers, I have trouble sitting still.
❑	❑	I must be doing something nearly all the time.
❑	❑	I am often “on the go” or act as if “driven by a motor.”
❑	❑	I talk excessively.
❑	❑	I take on projects simultaneously, but have trouble finishing them on time.
❑	❑	I am frequently in search of high stimulation.
❑	❑	I generally have a hard time relaxing.
❑	❑	I am generally impatient.
❑	❑	I smoke cigarettes.
❑	❑	I drink alcohol too much.
❑	❑	I change the radio station or TV channels frequently.
❑	❑	I was hyperactive as a child.
❑	❑	I would describe myself as hypersexual.

Impulsivity

As a child	Now	Behavior
❑	❑	I have a tendency to say what comes to mind without necessarily considering the timing or appropriateness of the remark.
❑	❑	I have trouble waiting my turn.
❑	❑	I tend to interrupt others.
❑	❑	I have trouble going through established channels in getting things done.
❑	❑	I am frequently impatient and have low frustration tolerance.
❑	❑	I spend money impulsively.
❑	❑	I am “hot-tempered.”
❑	❑	I am intolerant of boredom.
❑	❑	I have a tendency toward addictive behavior.
❑	❑	I have a hard time reading directions first.
❑	❑	I love to gamble.
❑	❑	I feel like exploding inside when someone has trouble getting to the point.
❑	❑	I often find myself involved in a situation without having planned it out.
❑	❑	I am accident-prone.
❑	❑	I have trouble keeping secrets.

Other

As a child	Now	Behavior
❑	❑	I have mood swings or mood lability.
❑	❑	I have chronic problems with self-esteem.
❑	❑	I have a history of underachievement.
❑	❑	I have trouble getting started on things.
❑	❑	I have the ability to "hyperfocus" on some projects or games.
❑	❑	I often procrastinate.
❑	❑	I have difficulty making myself understood to others.
❑	❑	I have tried cocaine and it slowed me down, rather than made me high.
❑	❑	I am unable to estimate time and space well.
❑	❑	I am drawn to situations of high intensity.
❑	❑	I have trouble with time-management.
❑	❑	I have trouble organizing (keeping an updated calendar or checkbook).
❑	❑	I work best in short spurts followed by a break.

Prior therapist information

Name:_____ Address:_____

City:_____ Zip:_____ Phone: ( )_____

- May we contact your previous therapist? ❑ Yes ❑ No, please explain: _____
  _____
- Please list any previous diagnoses: _____
  _____
- Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.
  _____
  _____

Family Mental Health History

- Has anyone in your *immediate or extended biological family* ever suffered from:

Condition	Who?	Comments
❑ Abuse Issues		
❑ ADHD/ADD		
❑ Alcoholism		
❑ Anxiety		

❑ Asperger's/Autism		
❑ Bipolar Disorder		
❑ Depression		
❑ Epilepsy/Seizures		
❑ Hyper/Hypothyriodism		
❑ Learning Disability		
❑ Psychosis		
❑ Substance Abuse		
❑ Suicidal Behavior		
❑ Other		

Everyone has something they worry about. Please describe five things that worry you:

1. _____

2. _____

3. _____

4. _____

5. _____

School History

Early Education

- Were you read to nightly as a child? ❑ No ❑ Yes
- Were you able to listen and attend to stories? ❑ No ❑ Yes
- Did you attend preschool? ❑ No ❑ Yes Type: _____
- Did you attend kindergarten? ❑ No ❑ Yes Name: _____

	Preschool Behavior
❑	Trouble learning alphabet, days of the week, colors, shapes, numbers
❑	Trouble following directions

Elementary School: _____

- Type of school: ❑ Public ❑ Private
  ❑ Regular education ❑ Special education ❑ Gifted program
- Type of program: ❑ Regular classroom ❑ Regular classroom with resource room
  ❑ Special day class (SDC) ❑ SDC with mainstreaming

	Elementary School Learning Issues
❑	Slow to learn the connections between letters and sounds
❑	Trouble learning to blend sounds to make words
❑	Made consistent reading and spelling errors
❑	Problems remembering sequences
❑	Trouble learning to tell time
❑	Slow to learn new skills
❑	Difficulty planning
❑	Slow to learn prefixes, suffixes, root words, and other reading strategies
❑	Avoided reading out loud
❑	Difficulty with word problems in math
❑	Avoided reading and writing tasks
❑	Worked slowly
❑	Difficulty understanding and/or generalizing concepts
❑	Frequently misread directions/information
❑	Confused the order of letters in words
❑	Didn't recognize words previously learned
❑	Didn't recognize the correct spelling of words
	Elementary School Attention Issues
❑	Trouble paying attention in class, often daydreaming
❑	Trouble sitting in chair to complete assignments
❑	Trouble with impulsive behaviors

Middle School: _____

- Type of school: ❑ Public ❑ Private
  ❑ Regular education ❑ Special education ❑ Gifted program
- Type of program: ❑ Regular classroom ❑ Regular classroom with resource room
  ❑ Special day class (SDC) ❑ SDC with mainstreaming
- Please describe any problems you had in middle school: _____

  _____

High School: _____

- Type of school: ❑ Public ❑ Private
  ❑ Regular education ❑ Special education ❑ Gifted program
- Type of program: ❑ Regular classroom ❑ Regular classroom with resource room

❑ Special day class (SDC) ❑ SDC with mainstreaming

- Please describe any problems you had in high school: _____

  _____

- High School GPA: _____ SAT Verbal: _____ SAT Math: _____

Undergraduate College(s):_____

- Major(s): _____, Degree(s): _____GPA: _____
- Please describe any problems you had in college: _____

  _____

Graduate School(s):_____

- Major(s): _____, Degree(s): _____GPA: _____
- Please describe any problems you had in graduate school: _____

  _____

School Performance

Please check the appropriate box rating your basic academic skills.

	Superior	Above Average	Average	Below Average	Very Poor	Typical Grade
Reading						
Language Arts						
Writing						
Math						
Science						
Social Science						

- Did you miss school regularly? ❑ No ❑ Yes
  If yes, please explain: _____
- Do you have a history of school conduct problems? ❑ No ❑ Mild ❑ Moderate ❑ Severe
- Have you ever been: ❑ Expelled ❑ Suspended ❑ In Saturday School
- Were you retained? ❑ No ❑Yes If yes, what grade? _____
- Do you think you've had a strong education to date? ❑ No ❑Yes
- List any clubs, sports, or school activities in which you participated:_____

  _____

Special Services (*Please check all special services you received)*

Service	Service

Speech/Language	❑	Adaptive P.E.	❑
Counseling	❑	Educational therapy	❑
Peer tutoring	❑	Teacher help	❑

- When were your academic problems first noticed? Who noticed them? What happened?

  _____

  _____

- Did you have an *Individual Education Plan* (IEP) written at school? ❑ No ❑Yes
- *Special accommodations* received at school: _____

  _____

- Do you demonstrate *visual perceptual* difficulties (e.g., letter reversals; confusion between similar letters such as b/d or p/q, words, or numbers; problems copying from the board; difficulty lining up math problems) ❑ No ❑Yes
- Have you demonstrated *auditory processing* difficulties (e.g., inconsistent following long oral directions; confusing similar sounding words such as mail and nail) ❑ No ❑ Yes
- Have you been aware of any *attentional or behavioral* problems? ❑ No ❑ Yes

- Favorite subjects: _____ Least favorite subjects: _____

Personality and Social Relationships

Personality (please use back of page as needed)

- Please describe your personality and general self-esteem: _____

  _____

- What are your favorite activities/interests? _____

  _____

Peer Relationships

- Number of close friends? ❑ None ❑ 1 ❑ 2-5 ❑ 6 +
- Are your satisfied with your friendships? ❑ No ❑ Yes
- My friendships are: ❑ Very close ❑ Somewhat close ❑ Lacking in closeness
- Please describe your friendships:_____

  _____

- Please describe any difficulties you may have with peer interactions:_____

  _____

Dating History

- Number of previous exclusive dating relationships: _____
- Age at first exclusive relationship: _____
- How do your relationships typically end?_____

  _____
- What are your relative strengths in these relationships? _____

  _____
- What are your relative weaknesses in these relationships? _____

  _____
- Are you satisfied with your dating experiences? ❑ No ❑ Yes
- Do you have any concerns about your sexual development or history? ❑ No ❑ Yes

  If yes, explain:_____

  _____
- Did you have trouble paying attention while completing this form? ❑ No ❑ Yes

Behavior History

Behavior Checklist (Please check all areas that were childhood issues)

❑ Aggression toward others	❑ Lying	❑ Substance abuse
❑ Aggression toward self	❑ Oppositional	❑ Tearfulness
❑ Anxious	❑ Passive/Withdrawn	❑ Temper tantrums
❑ Bed wetting	❑ Physical complaints	❑ Tired
❑ Depression	❑ Separation difficulties	❑ Trouble with law
❑ Eating problems	❑ Sexual acting out	❑ Truancy
❑ Fears	❑ Sleeping problems	❑ Other:_____
❑ Finger sucking	❑ Stealing	
❑ Immature	❑ Stuttering/Tics	

- Please describe any other behavioral problems that concern you: _____

  _____

  _____

Legal History

- Have you ever been in trouble with the law? ❑ No ❑ Yes If yes, please explain:

  _____

  _____

Please use the rest/back of this page to include any additional information you think I should know.