Center for Health, Learning & Achievement

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Adult Intake Questionnaire

Thank you so much for taking the time to fill out this form. This is a generic form, so some of the information will not apply to you. However, please fill it out as completely as possible. The pertinent information on this form will be included in the evaluation report, however, this form and the report will be kept confidential and remain in a secured clinical file. This information can only be released to others with your written permission.

Who can we thank for this referral? _____

Name:_____ **Years of Schooling: _____**
First Middle Last
Address:_____ **School _____**
_____ **Date of Eval.:_____**
Home Phone:_____ **Birthdate: _____**
Age: _____

Person filling out this form: _____

Reason for Referral

Presenting Problem:

Please explain your primary concerns (concerns, difficulties, questions):
_____
_____
_____
_____

How have these difficulties improved or deteriorated? _____
_____
_____
_____

Does anything seem to help alleviate some of the problems or concerns you experiences?_____

Is there anything that makes the problems or concerns worse? _____
_____

Demographics

Name:_____ **Age: _____**
Occupation: _____Business Phone:_____
Spouse's Name: _____ **Age: _____**

Occupation _____**Business Phone:**_____

What is the primary language spoken within the home? _____
Are there any other languages spoken within the home? _____

List all people living in the household:

Name	Age	Education

1

Family Health

A large majority of learning issues and emotional disturbances are hereditarily based Have any family members had any of the following? If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents if known.

Alzheimer's disease Or Dementia _____
Pituitary Gland dysfunction _____
Fragile X Chromosome _____
Cancer _____
Cystic Fibrosis _____
Diabetes _____
Hypoglycemia _____
Heart disease _____
High blood pressure _____
Kidney disease _____
Migraine headaches _____
Multiple sclerosis _____
Muscular dystrophy _____
Parkinson's disease _____
Pervasive Development Disorder __
Stroke _____

1

1

Anemia _____
Low or overactive Thyroid _____
Down's Syndrome _____
Double YY Chromosome _____
Tourette's Disorder _____
Asperger's Syndrome_____
Neurofibromatosis_____
Alcohol/drug abuse _____
Panic Attacks _____
Atmospheric Allergies _____
Emotional disturbance _____
Attention Deficit Disorder _____
Depression _____
Speech or language problem_____
Food allergies _____
Nervousness/ Anxiety_____
Seizures or epilepsy _____

Mental Illness (e.g. Bipolar Disorder, Manic Depression, Mania, Schizophrenia, Obsessive Compulsive Disorder) _____
Other: Describe _____

Learning Problems-
Reading of Words _____
Reading Comprehension _____
Spelling _____
Math Computation _____
Math Concepts _____
Handwriting _____
Written Expression _____
Oral Expression _____

Listening Comprehension _____

Has anyone in the family ever been identified for special education services ? No Yes
If yes, who? _____What type of class? _____

Personality and Temperament

2

How would you describe your personality? _____
_____

Choose those characteristics that apply to you

____ Lonely	____ Acts young for age	____ Flexible
____ Dependable	____ Acts old for age	____ Bored
____ Proper	____ Easily influenced	____ Hot Tempered
____ Intelligent	____ Enthusiastic	____ Independent
____ Daydreamy	____ Prim	____ Gets along well w/ others
____ Aggressive	____Pessimistic	____ Forgetful
____ Messy	____ Happy	____ Even Tempered
____ Resourceful	____ Bully	____ Detached
____ Antisocial	____ Victim	____ Submissive
____ Assertive	____ Energetic	____ Humorous
____ Optimistic	____ Shy	____ Stubborn
____ Rigid/Compulsive	____ Fearful	____ Compliant
____ Confused	____ Easily hurt feelings	____ Resilient
____ Unusual	____ Neat	____ Sensitive
____ Friendly	____ Underactive	____ Scattered Attention
____ Irritable	____ Overactive	____ Considerate
____ Graceful	____ Impulsive	____ Insecure
____ Lazy	____ Cries easily	____ Secure
____ Show-off	____ Self-conscious	____ Loving
____ Obedient	____ Likes to be alone	____ Jealous
____ Gentle	____ Often sad	____ Physical complainer
____ Drowsy	____ Helpful	____ Clumsy
____ Nervous	____ Disobedient	____ Dependent
____ Different	____ Fidgety	

3

Birth

At birth, what was your mother's age? _____ Father's age? _____

2

Were you:

_____ Premature: How premature? _____
_____ Late: How late? _____
_____ Full Term
_____ Don't know

Length of labor: _____ Hours

Birth weight _____lbs. _____oz.

Child's condition at birth _____
Mother's condition at birth _____

Check any of the following complications that occurred during birth

☐ Breech birth ☐ Labor induced ☐Vacuum ☐Cesarean delivery
☐ Forceps – Position of forceps _____
☐Other complications during delivery: Describe _____
_____

3

☐Neonatal care: Explain _____
_____

☐Incubator: How long? _____

☐ Jaundiced: Bilirubin Count (Circle One) Very High, High, Just Above Normal
Bilirubin lights? Yes No How long _____

3

☐ Breathing problems right after birth: Describe _____
Supplemental oxygen? Yes No How long _____

☐ Child had illnesses and/or Diseases; Describe _____

☐ Anesthesia used during delivery? Yes No What kind? _____

Length of stay in the hospital: Mother: _____days Child: _____days

If you did not come home from the hospital with the mother, why? _____
_____

Development

At about what age did you do the following? *Please indicate approximate month and/or year of age*

1

2

_____Sit alone
_____Crawl
_____Stand alone
_____Walk alone

_____ Show interest in or attraction to sound
_____Speak first words
_____Speak in sentences

3

Did you experience any of the following problems? **If yes, please describe**.

- Chronic ear infections No Yes _____
  Age of onset _____ Frequency _____
  Antibiotic Type(s) _____ Dosage _____
  Tubes ? Yes No Still Occurring? Yes No

5

- Walking difficulty No Yes_____
- Too Sensitive to Touch No Yes _____
- Too Sensitive to Sound No Yes _____
- Unclear speech No Yes _____
- Eating problems No Yes _____
- Underweight problem No Yes _____
- Overweight problem No Yes _____
- Colic No Yes _____
- Sleep problems No Yes_____
- Difficulty learning to throw or catch No Yes _____
- Difficulty learning to kick or hit No Yes _____

During the first 4 years, were any special problems noted in the following areas?
If yes, please describe.

6

- Excessive Anger (Rage) No Yes _____
- Separating from parents. No Yes _____
- Excessive crying No Yes _____
- Nail biting No Yes _____
- Failure to thrive No Yes _____
- Masturbation No Yes _____
- Motor skills No Yes _____
- Head bumping or banging No Yes _____

Which hand do you use for writing or drawing? _____

For Eating _____ For Throwing, Catching, etc_____

During the Preschool/Kindergarten years:

How well did you cut?
Poor Fair Good Excellent
How well did you glue?
Poor Fair Good Excellent
How well did you color in the lines?
Poor Fair Good Excellent

Later Development

From the age of 5 to the present time, were/are any special problems noted in the following areas?

If yes, please describe.

1

Difficulty learning to ride a bike No Yes_____
Difficulty learning to skip No Yes _____
Difficulty following directions No Yes _____
Difficulty following multiple directions No Yes _____
Difficulty articulating sounds, if so which sounds No Yes _____
Difficulty discriminating words that sound similar No Yes _____
Does/Did child often misspeak or substitute similar sounding words? No Yes
Difficulty telling a story in sequence No Yes _____

If a girl, when did you begin menstruation? _____

2

If a boy, when did you reach puberty? _____

At what age during adolescents did you begin to show signs of increased desire for independence? _____

Medical History

1

Have you had any of the following:
Serious accidents ____ No ____ Yes At what age? ____ Specify: _____
Serious illnesses ____ No ____ Yes At what age? ____ Specify: _____

Childhood Illnesses/Injuries

Please check the illnesses you have had and indicate age (year/month)

1

☐ Measles _____ ☐ Rheumatic fever _____
☐ German Measles _____ ☐ Diphtheria _____
☐ Mumps _____ ☐ Meningitis _____
☐ Chicken pox _____ ☐ Encephalitis _____
☐ Tuberculosis _____ ☐ Anemia _____
☐ Whooping Cough _____ ☐ Fever 104 or above _____
☐ Scarlet Fever _____
☐ Head injury: Describe-occurrence and location on skull _____
☐ Coma or loss of consciousness: Describe _____

1

☐ Seizure(s) Check behaviors evident during and immediately following seizure (378)
- ☐ Muscle twitches
- ☐ Hallucinations of flashes of light
- ☐ Numbness or tingling reported in a specific body part
- ☐ Image Hallucinations and/or complicated repetitive behavior, e.g. walking in circles
- ☐ Chewing movements/ Lip smacking
- ☐ Intense smell reported (pleasant or unpleasant)

Have you ever been on long-term prescribed medication (more than 6 months)? No Yes
If yes, when? _____ What kind? _____

2

Have you ever taken medication for an Attention Deficit Disorder? No Yes
If yes, what medication? _____ Dosage? _____

Have you ever used any of the following:

- ☐ Pep pills or uppers
- ☐ Alcohol
- ☐ Marijuana
- ☐ Diet pills
- ☐ None
- ☐ Tranquilizers or sedatives
- ☐ LSD or other hallucinogens
- ☐ Narcotics
- ☐ Other, specify _____

Do you or others think that you may have a problem with any of the substances listed above? No
Yes, specify substance _____

Are there any other factors, which could have caused insult to your central nervous system?_____

Please indicate whether you currently have any of the following problems. If yes, describe how often.

Frequent colds	No	Yes _____
Chronic cough	No	Yes _____
Asthma	No	Yes _____
Hay fever	No	Yes _____
Sinus condition	No	Yes _____
Shortness of breath or dizziness		
With physical exertion	No	Yes _____
Activity limitation due to:		
Heart condition	No	Yes _____
Heart murmur	No	Yes _____
Excessive vomiting	No	Yes _____
Frequent diarrhea	No	Yes _____
Constipation	No	Yes _____
Stomach pain	No	Yes _____
Nervous stomach	No	Yes _____
Bingeing and purging	No	Yes _____
Anorexia	No	Yes _____

3

Urination in pants/bed	No	Yes_____
Pain while urinating	No	Yes _____
Excessive urination	No	Yes _____

3

Muscle pain	No	Yes _____
		When? _____ Where? _____
Clumsy walk	No	Yes _____
Poor posture	No	Yes _____
Other muscle problems	No	Yes _____

Frequent rashes No Yes _____
Bruises easily No Yes _____
Sores No Yes _____
Severe acne No Yes _____
Itchy skin (eczema) No Yes _____

Brain Damage from known trauma No Yes If yes, describe _____
_____
Suspected Brain Trauma No Yes _____
Speech defects No Yes _____
3
Accident prone No Yes _____
Bites nails No Yes _____
Sucks thumb No Yes _____
Grinds teeth No Yes _____
Has tics/twitches No Yes _____
Bangs head No Yes _____
Rocks back and forth No Yes _____

Compulsive behaviors No Yes, describe _____
_____

Nonverbal Learning Disorder No Yes _____
Sensory Integration Dysfunction No Yes _____
Other Neurological Condition No Yes _____

Allergy to medicine No Yes If yes, describe _____
_____

3
Allergy to food No Yes If yes, describe _____
_____

Other allergies No Yes If yes, describe _____
_____

Ear infections No Yes _____
Hearing problems No Yes _____
Ear tubes No Yes _____
Date of most recent hearing exam _____

Vision problems No Yes _____
Wears glasses or contacts No Yes _____
Date of most recent eye exam _____

Medical Care
Your physician _____ Telephone _____
Address _____
How often do you see a doctor? _____ Date of last visit _____
Are you currently taking any medication? No Yes
If yes, indicate type and reason _____
_____

Educational History

List schools you have attended

2

Grade School Name(s) _____

City(s) _____

Grade Level(s) _____

3

Middle School Name(s) _____

City(s) _____

Grade Level(s) _____

4

High School Name(s) _____

City(s) _____

Grade Level(s) _____

Colleges _____

Degrees _____

GPA _____

Please indicate if you have had any of the following school experiences

Did you attend Kindergarten? No Yes

Any problems is Kindergarten? No Yes If yes, describe _____

_____

Did you change schools for reasons other than normal academic progression? No Yes

If yes, explain _____

Were you retained a grade in school? No Yes If yes, when and why? _____

_____

Did you skip a grade in school? No Yes If yes, when and why? _____

_____

6

In grade school (K-5) did you have difficulty with reading? No Yes

If yes, describe _____

In middle school (6-8) did you have difficulty with reading? No Yes

If yes, describe _____

In High School (9-12)? No Yes If yes, describe _____

_____

In grade school (K-5) did you have difficulty with math? No Yes

If yes, describe _____

6

In middle school (6-8) did you have difficulty with math ? No Yes
If yes, describe _____

In high school (9-12) did you have difficulty with math? No Yes
If yes, describe _____

In grade school (K-5) did you have difficulty with written expression? No Yes
If yes, describe _____

In middle school (6-8) did you have difficulty with written expression? No Yes
If yes, describe _____

In high school (9-12) did you have difficulty with written expression? No Yes
If yes, describe _____

Did you get poor grades? No Yes

_____

7

Have you ever been tested for special education services in the past. No Yes
When _____

8

Are you presently or did you ever receive some special education services or accommodations?

No Yes

If yes, describe _____

What areas did you have difficulty with in College? _____
_____
_____

9

Scores on the SAT (Verbal, Math and Combined) _____
Scores on any other Standardized Tests :
(Name of test and scores) _____

_____

_____

Primary difficulties on Standardized Exams (Comprehension, Working Within Time Constraints, Logical Reasoning, Written Expression, Mathematics, etc.)

_____

_____

_____

BEHAVIOR SYMPTOMS OF LEARNING DIFFICULTIES FOR STUDENTS

Name: _____ Date: _____
DOB: _____ Age: _____

_____1. Unhappiness with school
_____2. Complains about teacher(s)
_____3. Easily frustrated
_____4. Anxious; or _____4a panics under pressure
_____5. Reluctance to read
_____6. Reluctance to sit and be read to
_____7. Reluctance to study or _____7a do other sedentary tasks, e.g. _____
_____8. Poor study skills
_____9. Slow reading; or _____ poor reading
_____10. Difficulty with sounding out words
_____11. Is primarily a "sight reader"
_____12. Adds words, leaves out words, or substitutes words
_____13. Poor spelling; or _____13a does okay on spelling test but forgets words later
_____14. Poor vocabulary
_____15. Difficulty understanding what is read
_____16. Difficulty remembering what was read
_____17. Difficulty understanding what is heard
_____18. Difficulty remembering what was heard
_____19. Difficulty expressing thoughts _____19a verbally or _____19b in written form
_____20. Learning a foreign language very difficult even after hard study
_____21. Thinks concretely or literally; _____21a Can't "read between the lines"
_____22. Has difficulty foreseeing consequences
_____23. Trouble telling time or difficulty with minutes, hours, months, etc.
_____24. Difficulty understanding or telling jokes
_____25. Words appear to move, jiggle or dance
_____26. Skips line(s) when reading
_____27. Sees flashes of light or blotches when viewing page or screen
_____28. Words are blurry even though vision is okay or has corrective lenses
_____29. Doesn't see spaces or enough space between letters and/or words
_____30. Poor memory for what words say (can't recall what whole word says – not a "sight" reader) or seems to forget "the," "and," "when," "went," "there," etc.
_____31. Attempts to use phonetic spelling all of the time
_____32. Cannot write letters of the alphabet or cannot do so without great difficulty
_____33. Can't keep columns straight in math
_____34. Dislikes or hates math
_____35. Trouble with times tables and basic math facts
_____36. Can't understand new math concepts
_____37. Can't remember combinations
_____38. Distractible _____38a Hard to focus attention
_____39. Difficulty in following directions
_____40. Difficulty in getting work done; _____40a Difficulty following through
_____41. When does homework, forgets to turn it in
_____42. Disorganized and/or problems with sequencing and planning
_____43. Inaccurate copying
_____44. Sloppy or illegible writing
_____45. One or more biological family members have problems in (circle appropriate one(s)): reading, spelling, writing, enjoying reading, passing a grade or class
_____46. Has been held back or not passed a grade.
_____47. Had speech and/or language therapy
_____48. Is in or thought to need remedial reading (tutoring or class)
_____49. Is in or thought to need a learning disability (L.D.) class

SSIS CHECKLIST

GENERAL CHARACTERISTICS:

___reads in dim light
___never feels lighting is just right
___bothered by glare
___light sensitive

APPEARANCE OF THE EYES:

___reddened eyes and lids
___watery eyes

COMPLAINTS:

___headaches
___burning or itching eyes

___sandy, scratchy, dry eyes
___falls asleep when reading

___words double, move or look fuzzy

___words are blurry or fuzzy
___words disappear

OBSERVATIONS WHILE READING:

___rubs eyes
___moves closer to or further from reading material
___excessive blinking
___squinting
___opens eyes wide
___shades page with hand or body

___must incorporate breaks into reading
___moves the book to reduce glare

___closes or covers one eye
___moves head (tracks)
___reads close to the page
___reads word by word
___uses fingers or other marker routinely
___unable to skim or speed read

TYPES OF READING DIFFICULTIES:

___skips words or lines
___cannot read for longer than one hour
___loses place
___reading is slow and hesitant
___omits small words
___deteriorate as reading continues

COMPLAINTS ON COMPUTERS:

___eye strain and fatigue
___headaches
___trouble reading across columns

WRITING:

___writes up or down hill
___unequal spacing between letters and words
___inability to write on the line
___makes errors copying from books or board
___squints or blinks while copying from board

MATHEMATICS:

___misaligns digits in number columns
___difficulty seeing numbers in the correct column
___sloppy, careless errors

MUSIC:

___plays by ear and has difficulty reading musical notes

DEPTH PERCEPTION:

___difficulty getting on and off escalators
___clumsy
___walks into table edges or door jambs
___difficulty judging distances

For information on an Initial Screening for Scotopic Sensitivity Syndrome and Irlen Lenses contact:
Denton Kurtz

Attention-Activity Questionnaire

Please circle any of the following of I, II or IM, that have persisted for at least six months and are considered maladaptive and inconsistent with the person's developmental level.

I.
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
2. Often has difficulty sustaining attention in tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
5. Often has difficulty organizing tasks and activities.
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).
8. Is often easily distracted by extraneous stimuli.
9. Is often forgetful in daily activities.[1]

II.
1. Often fidgets with hands or feet or squirms in seat.
2. Often leaves seat in classroom or in other situations in which remaining seated is expected.
3. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).
4. Often has difficulty playing or engaging in leisure activities quietly.
5. Is often "on the go" or often acts as if "driven by a motor".
6. Often talks excessively.

IM.
7. Often blurts out answers before questions have been completed.
8. Often has difficulty awaiting turn.
9. Often interrupts or intrudes on others (e.g., butts into conversations or games).[2]

1. Which of the above circled symptoms were present prior to age seven? (list by letter(s) and number (i.e., I. #3, II. #5, and IM. #9):

_____
_____

2. Indicate the setting(s) where there is some impairment from the symptoms noted above: (please circle) home, school, work, social group, play, organized sport, other (specify)

_____

3. What clear evidence is there to demonstrate that there is significant impairment in social, academic, or occupational functioning?

_____
_____

4. Are there other possible reasons for the symptoms circled? Underline possible reason(s): e.g., depression, anxiety, manic-depression, loosely associated, post-traumatic stress, environmental factors such as loose or polar parenting styles, physical and/or sexual abuse, excessive guilt, fear from unknown sources, other

_____
_____

[1]Diagnostic and Statistical Manual of Mental Disorders: DSM-IV, 4th edition, American Psychiatric Association, Washington, DC, 1994. [2]Ibid.

Additional Comments

Have you ever had psychological counseling and/or exam? No Yes

If yes, psychiatrist or psychologist's name _____
Address _____
Telephone _____
Type of counseling _____
_____
_____
When? _____

Have you ever had a neurological exam? No Yes

If yes, Neurologist's name _____
Address _____
Telephone _____
Date of exam _____
Reason for exam _____
_____

Will you give us consent to speak with these practitioners and exchange information?

No Yes
Signature _____
Date _____