DEMOGRAPHIC FORM-ADULT EVALUATION

General Information

Full Name: _____ Today's Date: ____/____/_____ Date of Birth: ____/____/_____
Street Address (include ZIP code): _____
Phone Numbers:
Home: _____ Is it okay to leave a detailed message at this number? Yes _____ No _____
Cell: _____ Is it okay to leave a detailed message at this number? Yes _____ No _____

E-Mail Address: _____
Do I have your consent to email an appointment reminder prior to sessions? Yes _____ No _____
Do I have your consent to email digital copies of:
1) Records: Yes _____ No _____
2) Billing statements: Yes _____ No _____

Emergency Contact: _____ Phone #: _____

Please tell us a little more about yourself:
Gender/Preferred Pronouns: _____
Ethnicity/Cultural identity: _____
Spiritual beliefs: _____
Disabilities (any): _____
Sexual orientation: _____
Occupation and/or School & Major: _____
Handedness (right/left/ambidextrous): _____

Who referred you to our service? Please provide contact information: _____

Is this referral a result of or related to any legal or court proceedings? If so, please provide name of attorney.
_____

Please list the reason(s) you are seeking this evaluation: _____
_____

How long have these problems occurred? (number of weeks, months, years): _____

Have you had previous neuropsychological testing? Yes _____ No _____
If Yes, where? _____ When? _____
Have you had any additional testing (e.g., psychoeducational, speech/language?) Yes _____ No _____
If Yes, where? _____ When? _____
**If you answered Yes to either of the above questions, please attach or otherwise provide report(s).*

Please list any other healthcare providers involved in your care (e.g., neurologists, other physicians, occupational therapists, etc.): _____
_____

Developmental/Medical History

Pregnancy and Birth (your own, not your children's – leave blank if unknown)

Pregnancy/Birth/Delivery Complications? Please Describe: _____
_____

Medications used during pregnancy? _____

Did your mother engage in any of the following during pregnancy?

Yes _____ No _____ Smoking? How much? _____
Yes _____ No _____ Drug intake? Type? _____ How much? _____
Yes _____ No _____ Alcohol consumption? How much? _____

Length of pregnancy?
(weeks): _____
Age of mother at birth: _____
Birth weight: _____lbs. _____oz.
Birth length: _____
APGAR scores? _____/_____

Type of delivery (check please): _____spontaneous _____induced _____cesarean _____with instruments _____breech

Any complications for mother or infant (yourself) after birth? Please explain:
_____
_____
_____

Developmental Milestones

Yes _____ No _____ Did you enjoy cuddling?
Yes _____ No _____ Were you fussy or irritable?
Yes _____ No _____ Were you more active than other babies?
Yes _____ No _____ Was your development significantly different than your siblings? If yes, please explain:
_____
_____

At what age did you first do the following (indicate with year and month of age).

_____ Turn Over _____ Crawl _____ Stand Alone _____ Walk Alone
_____ Walk Upstairs _____ First Words _____ First Phrases

Toilet Trained during the day by age 5? Yes _____ No _____
Did bed wetting or soiling occur after training? _____ Wetting _____ Soiling If yes, until what age? _____

Did you have any speech difficulties? _____
Motor difficulties (e.g. clumsiness)? _____

Medical History

Has your medical history been normal/unremarkable? Yes _____ No _____
If no, please explain: _____
_____
_____

Have you received any medical diagnoses? Yes _____ No _____
Please explain: _____
_____
_____

Circle All that Apply:

Yes No Have you completed genetic testing?
Yes No Have you had an MRI?
Yes No Have you had an EEG?
Yes No Frequent ear infections?
Yes No Were ear tubes ever placed?
Yes No Hearing problems?
Yes No Vision problems?
Yes No Headaches?
Yes No Meningitis?
Yes No Seizures?
Yes No Asthma?
Yes No Slow/fast growth?
Yes No Head injury?
Yes No Allergies?
Yes No Hospitalizations?
Yes No Have you experienced anything you would call traumatic (physical, verbal, or emotional abuse; unwanted sexual experiences; accidents or other events)?

Have you ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications do you currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your sleep routine:

Typical bed time: _____ Typical wake time: _____
Trouble falling asleep? **Yes No** Trouble staying asleep? **Yes No** Trouble waking up early? **Yes No**

Any other sleep problems? Explain: _____
_____

Describe your diet: _____
_____

Describe your current level and type(s) of exercise: _____
_____
_____

Mental Health History

List any previous or current mental health diagnoses: _____
_____

Have you received therapy services or counseling in the past? **Yes No**
Name of provider: _____ Dates: _____
Name of provider: _____ Dates: _____
Name of provider: _____ Dates: _____

Are you currently seeing a psychiatrist for medication? **Yes No** Have you in the past? **Yes No**
Name of Psychiatrist: _____ Dates of treatment: _____
Medication(s) Prescribed: _____

Is there a history of self-harm or suicidal thoughts, threats, or attempts? Please explain: _____
_____

Have you ever been hospitalized for mental health concerns? Please explain: _____
_____

Do you have a history of angry outbursts? **Yes No**
If yes, please explain: _____

Have you ever physically assaulted another person, animal, or object? **Yes No**
If yes, please explain: _____

Psychosocial Functioning

Describe your personality: _____
_____
_____

What are your non-academic strengths? _____

What are your non-academic weaknesses? _____

How do you spend your free time? _____
_____
_____

What is your current level of alcohol and/or drug use?
Alcohol: _____ Recreational drugs:
_____

How is your social group? Do you have close friends? Any trouble initiating or maintaining relationships?
_____
_____
_____
_____

Please place a mark next to behaviors that you believe you experience to an *excessive or exaggerated degree* when compared to others your age.

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with others
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Impulsive (does things without thinking)
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor
- ❑ History of vocal or motor tics
- ❑ Poor sense of danger/risk
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug use
- ❑ Alcohol use

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Excessive snoring during sleep
- ❑ Decreased need for sleep without getting tired
- ❑ Eating excessively
- ❑ Eating Poorly

Social

- ❑ Prefer to be alone
- ❑ Excessively shy or timid view
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Not sought out for friendship by peers
- ❑ Excessive daydreaming and fantasy life
- ❑ Difficulty seeing another person's point of view
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ "Clumsy" in general

Academic History

Did you ever have an IEP or 504 Plan, or other modified learning program or participation in special education services when younger? **Yes No**

If yes, please describe: _____
_____
_____

What was your high school GPA: _____
What was/is your college GPA: _____
Grad school GPA: _____

How do you generally perform on standardized tests? _____
_____

What are your strongest and weakest points, academically? _____
_____

Legal History

Have you been involved with the court currently or in the past? _____
Date(s): _____
Describe: _____
_____
_____

Currently on Probation? **Yes No** Probation Officer: _____ Phone #: _____

Family History

Are you (choose one): **Married** **Living Together** **Separated** **Divorced** **Single**

If married, for how long? _____
If separated or divorced, when? _____
Do you have children? Ages? _____
Who else lives in your home? _____
_____

Have any of the following diseases occurred among your blood relatives (parents, aunts, uncles, grandparents)? Check all that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD
- ❑ Bleeding tendency
- ❑ Depression
- ❑ Cancer
- ❑ Suicide
- ❑ Learning problems
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety
- ❑ Autism/Asperger's
- ❑ Intellectual disability/ cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Schizophrenia
- ❑ Dementia/cognitive decline
- ❑ Other (specify):

_____