Johnson Neuropsychology, PLLC
Adult Intake Questionnaire

In order for us to be able to fully evaluate you, we request that you fill out the following intake forms completely to the best of your ability. We realize that there is a lot of information, but every question is important. Please get assistance from a family member or person who knows you well, if necessary, to complete the forms accurately—if no one is available to assist you, just do the best you can. Thank you!

NAME: _____ **DATE:** _____
ADDRESS: _____ **DATE OF BIRTH:** _____
_____ **AGE:**_____
TELEPHONE: _____ **HANDEDNESS (circle one):**
EMAIL:_____ Right Left Ambidextrous
REFERRAL SOURCE: _____ **HIGHEST GRADE COMPLETED**:_____
ETHNICITY:_____ **OCCUPATION:** _____

Who is completing this form? Self or Other:_____

How did you/will you get to the clinic?: Friend Taxi Drive myself Family member Bus Walk Bike

Please explain in your own words why you are seeking services today.
When did your problem start?
How has your problem progressed or worsened?
Has this problem affected your performance at school and/or work? Yes ❑ No ❑
If yes, how?
How much is daily life impacted? Severe [ ] Moderate [ ] Mild [ ] None [ ]

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) _____
_____
_____
_____

What are the top four (4) symptoms or problems that you would like to see improved?
1 _____
2 _____
3 _____
4 _____

MEDICAL HISTORY: *Have you ever had any of the following?*

			Describe
Loss of Consciousness or Fainting ……	Yes	No	
Concussion, head injury, or hit/bump head…….	Yes	No	
High Fever……....	Yes	No	
Oxygen Deprivation…….	Yes	No	
Encephalitis……..	Yes	No	
Meningitis……..	Yes	No	
Brief episodes that included:			
Numbness or Tingling in parts of your body ..	Yes	No	
Changes in your vision…….	Yes	No	
Weakness in parts of your body……...	Yes	No	
Problems with taste or smell……	Yes	No	
Problems with nausea……..	Yes	No	
Headaches…….	Yes	No	
High Fever……	Yes	No	
Seizure…….……	Yes	No	Last one:_____ How often:_____Type;_____
Diabetes……..	Yes	No	
Balance Problems……...	Yes	No	
Urinary Incontinence……..	Yes	No	
High Blood Pressure……...	Yes	No	
High Cholesterol……....	Yes	No	

List other CURRENT **Medical Problems**: _____

_____

_____

_____

Hospitalizations for serious illness or accident (when, where, why, how long?):

_____

_____

_____

_____

Any periods of spaciness or confusion? Yes or No _____
Prior abnormal lab tests, X-rays, EEG, etc.: _____
Allergies/drug intolerances? Yes or No (describe): _____
Ever been tested for **food allergies**? Yes or No *Describe* _____
*Ever had or suspected to have a **thyroid disorder**? Yes or No*
*Ever had or suspected to have **blood sugar problems (hypoglycemia) or diabetes**? Yes or No*

FEMALES ONLY: Problems with hormones or irregular monthly cycle? Yes or No
*Describe.*_____
Circle One: Are you in perimenopause, menopause, post-menopause? *Yes or No* Do you take hormones? *Yes or No*

Present Height _____ Present Weight _____
Vision (circle): Normal Corrected Needs to be checked
Hearing (circle): Normal Corrected Needs to be checked
Have you ever heard or seen things that others around you have not? Yes No

SLEEP BEHAVIOR (circle all that apply): sleepwalking nightmares recurrent dreams
difficulty falling asleep wake up during the night difficulty getting up no problems with sleep
Other:_____
What time do you go to bed?_____ What time do you wake-up?_____

How many hours of sleep do you get at night?_____ During the day? _____

Do your legs jump often or do you kick your blankets off at night? Yes No
Do you snore? Yes No If yes, Are you overweight? Yes No
Do you have periods that you stop breathing (ask your bed partner) Yes No

MEDICATIONS:

Please list all medications you are currently taking, along with information regarding what disorder they are prescribed to treat, the dosage, how often, and what time of day you take them. *Please include all over-the-counter, herbal, and "nontraditional" medicines. Attach a sheet if necessary.*

Name of medicine	Taken for?	Dosage	When/How often?
What side effects do you experience from your medications (if any)?			

GENERAL HEALTH/NUTRITION:

Do you exercise regularly? Yes No What do you do for exercise? _____
How many cups of coffee or other caffeinated beverages such as soda or Red Bull type drinks do you drink a day? ____
How many diet sodas or beverages with artificial sweeteners do you drink per day**?**_____
How many times do you eat per day? _____

PSYCHIATRIC HISTORY:

Describe

Have you ever had any mental health problems?…...Yes No _____
List all *DIAGNOSES* ever given with *DATES*:_____
_____
Ever been **prescribed meds** for mental health problems?....Yes No_____
Ever **hospitalized** for mental problems?…….…Yes No _____
Have you ever attempted **suicide**?…...……...Yes No _____
Ever had **counseling or therapy**?.....Yes No Dates:_____ Was it helpful? Yes No
Have you been the victim of physical abuse? □ Yes □ No By whom?_____
sexual abuse? □ Yes □ No By whom?_____
emotional abuse? □ Yes □ No By whom?_____
Have you witnessed extreme violence? □ Yes □ No Please describe:_____

ALCOHOL AND DRUG HISTORY:

Do you use alcohol (hard liquor, beer, wine)?..... Yes No How often? _____
Do you use recreational drugs?….....Yes No How often? _____
Which type of drugs?_____
Have you used in the past?.....Yes No Year stopped:_____
Which type of drugs?_____
Do you experience **withdrawal symptoms** from alcohol or drugs? Yes No Withdrawal in the past? Yes No
Has anyone told you they thought you had a problem with drugs or alcohol?.....Yes No
Have you ever felt guilty about your drug or alcohol use?.....Yes No

Have you sought treatment for drugs or alcohol? Yes No If yes, describe below:

Name of Program/Facility	Year	Inpatient or Outpatient	# of Days or Months of Treatment	Completed Program?
				Y N
				Y N
				Y N
				Y N

Tobacco use: Current Use (Last 30 days): Yes No Past Use: Yes No If yes, when did you stop?_____
Length of Use: _____ How Much: _____

DEVELOPMENTAL HISTORY: Are you aware of any of the following?

Problems during prenatal development? Yes No_____
Exposure to drugs or alcohol prenatally? Yes No_____
Developmental delay in Speech/language? Yes No_____
Motor Skills? Yes No_____
Physical Development? Yes No_____
Social Development? Yes No_____
Other Serious Childhood Injury? Yes No_____

SCHOOL HISTORY: How many years of education do you have?_____
If you did not graduate from high school, why ?_____GED? □ Yes □ No
Were you in **special education classes**? □ Yes □ No If yes, what grade did you start and why?_____
What have teachers said about you? _____
Did you attend a **college or university**? Yes No What was your major?_____ Graduate? Yes No
If No, why not?:_____
Name of College or University:_____ Years attended _____
Do you have any **specialized or vocational training**? □ Yes □ No Please describe _____
Describe any academic problems you had in college or university._____
_____
_____
_____

OCCUPATIONAL HISTORY: (Please list most current jobs first and then past jobs for PAST 5 YEARS.)

Job Employer Approximate Dates Reason for Leaving Hours worked per week
_____
_____
_____
_____
_____

*Any **work-related problems**? Problems getting along with the boss or coworkers? Problems completing work?*
_____
_____
_____

Have you ever been fired? □ Yes □ No If so, why?_____

DISABILITY: Yes No If yes, since when:_____ What caused the disability?_____ Do you receive Social Security benefits? Yes No
Do you receive private disability benefits? Yes No

MILITARY HISTORY: Yes No Branch:_____ **Combat? □ Yes □ No** Date of discharge:_____

LEGAL HISTORY:

Have you ever been arrested? □ Yes □ No If yes, give dates and charges: _____
Have you been incarcerated? □ Yes □ No If so, give dates: _____
Are you on parole or probation? □ Yes □ No If yes, for how long? _____

FAMILY HISTORY

Marital Status: Single: ___ Separated: ___ Widowed: ___ Married: ___ Divorced: ___ Same-Sex Partner: __
What city and state did you grow up in?_____
How many siblings did you have growing up? Brothers _____ and Sisters _____
Were you the… Youngest Middle Eldest
When you were growing up, were your parents… Together Single Divorced Separated
If not together, how old were you when they split up? _____ Who raised you after? _____

Did you move around a lot?
Explain._____
Describe your current living
arrangements:_____

Biological Mother's History: age_____ occupation _____
School: highest grade completed _____
Has mother ever sought psychiatric treatment? Yes ___ No ___If yes, for what purpose? _____
Biological Father's History: age_____ occupation _____
School: highest grade completed _____
Has father ever sought psychiatric treatment? Yes ___ No ___If yes, for what purpose? _____

If you have children, please list their ages: _____
Do your children live with you? □ Yes □ No If no, who do they live with?_____

Ever CPS involvement?_____

Family History of any of the following?			**Family Member**
Dementia or Alzheimer's……...…….	Yes	No	_____
Stroke……..	Yes	No	_____
Seizures…….....Yes		No	_____
Depression……...……	Yes	No	_____
Anxiety……..Yes		No	_____
Manic Depressive or Bipolar……	Yes	No	_____
Learning disability…….Yes		No	_____
ADD/ADHD…….……Yes		No	_____
Drug or alcohol abuse..……	Yes	No	_____
Other serious medical or mental health condition	Yes	No	_____

Additional Information
If there is anything else about your case that you think is important for us to include in your report to help decide on appropriate action for your case, please include it in the space below.
✯ *Thank you for completing this form.* ✯

MINI SCREEN 6.0.0

Patient Name : _____ ***DATE OF BIRTH:*** _____

DATE OF SCREENING: _____ ***If YES**, go to the corresponding M.I.N.I. module*

➢ Have you been depressed or down, **most of the day, nearly every day,** for the past two weeks?	NO	YES	→ **A**
➢ In the past two weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy **most of the time**?	NO	YES	→ **A**
➢ In the past month did you think that you would be better off dead or wish you were dead?	NO	YES	→ **B**
➢ In the past month have you thought about killing yourself?	NO	YES	→ **B**
➢ Have you **ever** had a period of time when you were feeling 'up' or 'high' or 'hyper' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	NO	YES	→ **C**
➢ Have you **ever** been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified?	NO	YES	→ **C**
➢ Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells surge to a peak, within 10 minutes of starting? CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES.	NO	YES	→ **D**
➢ Did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	NO	YES	→ **D**
➢ Do you feel anxious or uneasy in places or situations where help might not be available or escape might be difficult: like being in a crowd, standing in a line (queue), when you are away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car?	NO	YES	→ **E**
➢ In the past **month** did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.	NO	YES	→ **F**
➢ In the past **month** have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (e.g., the idea that you were dirty, contaminated **or** had germs, or fear of contaminating others, **or** fear of harming someone even though you didn't want to, **or** fearing you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions.)	NO	YES	→ **G**
➢ In the past **month**, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, or arranging things, or other superstitious rituals?	NO	YES	→ **G**

IF YES, GO TO THE CORRESPONDING M.I.N.I. MODULE

- Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER. NO YES → **H**
- Did you respond to the trauma with intense fear, helplessness, or horror? NO YES → **H**
- During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)? NO YES → **H**
- In the past **12 months**, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? NO YES → **I**
- Now I am going to show you a list (**OR READ THE LIST BELOW)** of street drugs or medicines.* In the past **12 months**, did you take any of these drugs more than once, to get high, to feel elated, to get a buzz, or to change your mood? NO YES → **J**

amphetamines	speed, crystal meth	Dexedrine®, Ritalin®	diet pills, rush	THC, marijuana, cannabis, hashish
Cocaine, crack	steroids, GHB	Valium®, Xanax®	Ativan	barbiturates
heroin	morphine, methadone	opium, Demerol®	codeine	Percodan®, OxyContin®, Vicodin®
LSD, mescaline	PCP, angel dust, ecstacy	MDA, MDMA	ketamine	inhalants glue, ether

- Have you ever believed that people were spying on you or that someone was plotting against you or trying to hurt you? NO YES
- Have you ever heard things other people couldn't hear such as voices? NO YES
- Have you ever had visions when you were awake or have you ever seen things other people couldn't see? NO YES
- How tall are you?
  |__|__|__| inches
- What was your lowest weight in the past 3 months?
  |__|__|__| lbs

IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS/ HER HEIGHT? NO YES → **M**

Height (ft in)	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7
Weight (lbs)	81	84	87	89	92	96	99	102	105	108	112
Height (ft in)	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3			
Weight (lbs)	115	118	122	125	129	132	136	140			

- In the past **three months**, did you have eating binges or times when you ate a very large amount of food within a **2-hour** period? NO YES → **N**
- In the last **3 months**, did you have eating binges as often as twice a week? NO YES → **N**
- Were you **excessively** anxious or worried about several routine things over the past 6 months? NO YES → **O**

* ALL BRANDS LISTED ARE TRADEMARKS OF THEIR RESPECTIVE OWNERS