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: _____ EDUCATION: _____ years
ETHNICITY: _____ OCCUPATION: _____

THIS FORM WAS COMPLETED BY: _____
RELATION TO PATIENT: _____

What are the top five (5) symptoms or problems that <u>you</u> would like to see improved?
1 _____
2 _____
3 _____
4 _____
5 _____

When did you first notice these difficulties? _____

How much is daily life impacted? Severe [ ] Moderate [ ] Mild [ ] None [ ]

<u>MEDICAL HISTORY</u>: ***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 Grand Mal Petit Mal Absence How often: _____
Diabetes…… Yes No _____
Balance Problems…… Yes No _____
Urinary Incontinence…… Yes No _____
High Blood Pressure…… Yes No _____
High Cholesterol……... Yes No _____

Other CURRENT or PAST Serious illnesses: _____

_____

CURRENT MEDICATIONS, Supplements, including Over the Counter (OTC) Medicine (e.g., Tylenol) & Dosages

Medication, Supplements, or OTC	Dose	Date started	Is it beneficial? Circle one	List any side effects
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	
			Helps Doesn't Help Unsure	

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
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 wakes up during the night difficulty getting up no problems with sleep
Other:_____
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

GENERAL HEALTH/NUTRITION:
Do you exercise regularly? Yes No What do you do for exercise? _____
How many 8oz. cups of caffeinated coffee do you drink a day? _____
How many 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**?**_____

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: Last grade *completed* _____ Did you receive a GED or high school diploma? (Circle one)
Average grades received _____ Did you receive services through Special Education? Yes No
Were you diagnosed with a learning disability? Yes No Explain: _____
Any behavior problems in school? _____
What have teachers said about you? _____
Did you attend college or University? Yes No What was your major?_____ Graduate? Yes No
Name of College or University:_____ Years attended _____
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	FT/PT

Any work-related problems?

_____
_____

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:_____ Date of discharge:_____

PSYCHIATRIC HISTORY:

Describe

Have you ever had any mental health problems?…...Yes No _____
Ever prescribed meds for mental health problems?....Yes No_____
Ever hospitalized for psychiatric care?……Yes No _____
Have you ever attempted suicide?…..……...Yes No _____
Ever had counseling or therapy?.....Yes No Dates:_____ Was it helpful? Yes No

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

_____

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

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

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? _____

CURRENT COGNITIVE SYMPTOMS: **1=Never 2=Sometimes 3=Often 4=Almost Always**

SELF	OTHER	
		Fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
		Has difficulty sustaining attention in tasks or play activities
		Does not seem to listen when spoken to directly
		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)
		Has difficulty organizing tasks and activities
		Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort
		Loses things necessary for tasks or activities
		Easily distracted by things you hear or see
		Forgetful in daily activities
		Fidgets with hands or feet, tapping fingers or shaking leg while seated
		Leaves seat in situations in which remaining seated is expected
		Runs about (in adults, may be limited to subjective feelings of restlessness)
		Has difficulty playing or engaging in leisure activities quietly
		Is "on the go" or often acts as if "driven by a motor"
		Talks excessively
		Blurts out answers before questions have been completed
		Often has difficulty awaiting turn
		Often interrupts or intrudes on others (e.g., butts into conversations or games)

Memory: **Check all that apply**

Yes No Difficulty with Short-term Recall – Difficulty remembering newly learned experience
Yes No Difficulty with Long-term or Remote Recall – Difficulty remembering past experiences/events
Yes No Absent-Mindedness
Yes No Poor Memory for Names/Faces
Yes No Difficulty with Old Learning (e.g., balancing a checkbook, taking a bus, recipes, simple math or spelling)
Yes No Difficulty with New Learning (able to learn something new involving 3 or 4 steps)
Yes No Memory gets worse AT THE END OF THE DAY
Yes No Memory is worse ALL OF A SUDDEN
Yes No Memory has gotten worse GRADUALLY
Yes No Memory problems occur OFF AND ON

Speech:

Yes No Difficulty Expressing Thoughts
Yes No Difficulty Understanding Others…Is it due to poor hearing? Yes No
Yes No Change in Articulation/Slurred or Mumbled Speech
Yes No Trouble Finding Correct Word or Desired Word
Yes No Saying Wrong or Inappropriate Word

Thought Processes:

Yes No Trouble Organizing Thoughts or Actions
Yes No Slowed Thinking
Yes No Decreased Problem Solving Ability
Yes No Changes in Ability to Read or Write or Spell
Yes No Changes in Ability to Do Math or With Handling Money
Yes No Changes in Handwriting

FAMILY HISTORY

Marital Status: Single: ___ Separated: ___ Widowed: ___ Married: ___ Divorced: ___ Same-Sex Partner: ____

What city and state did you grow up in?_____

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

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

Siblings (names, ages, problems, strengths)

_____

_____

Children (names, ages, problems, strengths)

_____

_____

Family History of any of the following? **Family Member**

Dementia or Alzheimer's……...……Yes No _____
Stroke……...Yes No _____
Seizures…….....Yes No _____
Heart Disease……...……Yes No _____
High Blood Pressure……..Yes No_____
Depression……...……..Yes No _____
Anxiety……..Yes No_____
Manic Depressive or Bipolar…….Yes No_____
Learning disability……Yes No_____
ADD/ADHD…….……Yes No_____
Substance abuse…… Yes No_____
Other serious medical or mental health condition Yes No _____

ACTIVITIES OF DAILY LIVING

Do you keep in contact with or visit friends? Yes No How often? _____

If you're not working, where do you get your financial support? _____

Are you able to (circle all that apply): Bathe yourself Groom yourself Cook Shop
Clean house Pay Bills Manage your money Use the bus Drive

How do you like to spend your time?_____

Please list any hobbies or pastimes you enjoy. _____

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** → **B**
➢ In the past month have you thought about killing yourself?	NO	YES	
➢ 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** → **D**
➢ Did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	NO	YES	
➢ 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** → **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	

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