Developmental Neuropsychology Services, PLLC
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Intake Questionnaire – College student

Patient's Name:____ Today's Date:___________

Birthdate:_______________________________ Age:_______ Gender (circle one): Male Female

Ethnicity:_____________ Marital Status:_______________

Contact Phone (home or cell):_______________________

Home address (please include zip code):_______________________________________

____

College address (if different from above): please circle: dorm apartment house other

____

Employer:________________________________Occupation:____________________________

Person filling out this form (circle one): Patient Mother Father Other (please explain):______________

Family History (Please circle Birth, Adoptive, or Step)

Birth / Adoptive / Step Mother's Name:______________________ Education:______________

Birthdate:_______________________________ Home Phone:_______________________

Home mailing address including zip code:_______________________________________

Employer:____

Occupation:_____________________________ Work Phone:_______________________

Birth / Adoptive / Step Father's Name:______________________ Education:______________

Birthdate:_______________________________ Home Phone:_______________________

Home mailing address including zip code:_______________________________________

Employer:____

Occupation:_____________________________ Work Phone:_______________________

Other Guardian Name(s):__________________________________ Education:______________

Birthdate:_______________________________ Home Phone:_______________________

Home mailing address including zip code:_______________________________________

Employer:____

Occupation:_____________________________ Work Phone:_______________________

Siblings

Name *Age* *Relationship to patient including biological, foster, or adoptive*

____

____

____

____

Do you have children? ______ Yes ______ No (If yes, list below)

Name *Age* *Relationship to patient including biological, foster, or adoptive*

____

____

____

____

Primary language spoken in the home:____

Other languages spoken in the home:____

Referral Information

What questions are you hoping this evaluation will answer? What information are you hoping to obtain?

____

____

____

____

How long has this been of concern to you? ____

What seems to help the situation? ____

____

What seems to make this situation worse? ____

____

Who referred you for evaluation?

____

Has the patient received evaluation or treatment for the current issue or similar issues? Yes ____ No ____

If yes, when and with whom? ____

____

Is the patient on any medication **at this time**? Yes ____ No ____

If yes, list medication (s), dosages, and name of professional monitoring the medication. Also indicate the patient's response to the medications, both positive and negative effects.

____

____

____

Have there been any major recent changes or stressors (e.g., starting college, deaths, moves, divorces, loss of job, new job, etc.)? ____ No ____ Yes (describe below)

EVENT DATE

____

____

____

____

Medical History

Were there any problems during the pregnancy or birth? ____ No ____ Yes (specify)

____

____

Was the patient ever described as having developmental problems? ____ No ____ Yes (specify)

____

____

Place a check next to any illness or condition that the patient has had. When you check an item, also note the approximate date (or age) of the illness.

Check if yes	*Illness or condition*	*Date (s) or age(s)*	*Check if yes*	*Illness or condition*	*Date(s) or age(s)*
_______	Measles	_______	________	Dizziness	______
_______	German measles	_______	________	Frequent or severe	______
_______	Mumps	_______		headaches	
_______	Chicken Pox	_______	________	Difficulty concentrating	______
_______	Whooping Cough	_______	________	Memory problems	______
_______	Diphtheria	_______	________	Extreme tiredness or	______
_______	Scarlet fever	_______		Rheumatic fever	______
_______	Encephalitis	_______	________	Epilepsy	______
_______	Fever over 104	_______	________	Tuberculosis	______
_______	Convulsions	_______	________	Bone or joint disease	______
_______	Allergy	_______	________	Gonorrhea or syphilis	______
_______	Hay fever	_______	________	Anemia	______
_______	PE Tubes	_______	________	Jaundice/hepatitis	______
_______	Broken bones	_______	________	Diabetes	______
_______	Hospitalizations	_______	________	Cancer	______
_______	Operations	_______	________	High blood pressure	______
_______	Ear problems	_______	________	Heart disease	______
	(disease, infection,		________	Asthma	______
	injury, or impaired hearing)		________	Bleeding problems	______
_______	Visual problems	_______	________	Eczema or hives	______
_______	Fainting spells	_______	________	Suicide attempt	______
_______	Pregnancy	_______	________	Loss of consciousness	______
_______	Paralysis	_______	________	Other______________	______
_______	Injuries to head	_______			

Please describe the head injury. Was there loss of consciousness? Did it require sutures? Did it result in a concussion, etc? ____

____

Please describe other serious illnesses, need for stitches, or operations:

Illness / Operation *Age*

____

____

____

Please list any medications the patient has received in the past for medical or psychological/behavioral problems. Also describe what sort of response (e.g., effective, slightly effective, not effective). Also list specific side effects, if any. Use the margins or additional paper if necessary.

Date Started	*Date Stopped*	*Medication*	*Dose*	*Response*	*Reason for Medication*
__________	___________	____________	______	_____________	__________________
__________	___________	____________	______	_____________	__________________
__________	___________	____________	______	_____________	__________________
__________	___________	____________	______	_____________	__________________

Has the patient ever had psychological counseling or therapy? Yes _______ No _______

If yes, counselor's name____

Counselor's Address____

Telephone____

Type of counseling and for what issues____

When____

Did you find it helpful? ______ No _______ Yes

Has the patient ever attempted suicide? Yes ________ No________

If yes, when?___________________________ How?____________________________

Please describe the circumstances that led up to the suicide attempt:______________________

____

____

Did the patient receive any therapy after this suicide attempt? Yes_____ No______

Has the patient ever had a neurological exam? Yes ________ No________

If yes, neurologist's name________________________ Date of Exam______________

Neurologist's Address ____

Has the patient ever had a psychiatric evaluation? Yes ________ No________

If yes, doctor's name________________________ Date of Evaluation______________

Doctor's Address ____

Reason for exam ____

Has the patient ever been hospitalized in a psychiatric facility? Yes ________ No________

If yes, when? ________________________ Where? ___________________

Reason? ____

Has the patient ever experienced any type of abuse (e.g., physical, emotional, sexual, neglect)?

Yes ________ No_________

If yes, what type?_______________________ When?___________________________

Please describe: ____

____

Please list any and all diagnoses the patient has ever been given (e.g., ADHD, Learning Disabled, PDD, Tourette's, Bipolar, Depression, Anxiety, Asperger's Disorder) and note approximate date of diagnosis.

____

____

Medical Care

Physician ____ Telephone ______________

Physician's Mailing Address ____

How often does your son or daughter see a doctor? _______________ Date of last visit___________

Family Medical History

Place a check mark next to any illness or condition that any member of the extended family has had. When you check an item, please specify family member's relationship to the patient **(please include "M" if the relative is from the mother's side or "P" if the relative is from the father's side: example – M. Aunt would be the child's aunt from the mother's side of the family, for the child's mother, father, or siblings, simply note "mother," "father," "brother," "sister"**).

Check if yes	*Condition*	*Relationship to child*	*Check if yes*	*Condition*	*Relationship to child*
_______	Alcoholism	_______	________	Depression	______
_______	Schizophrenia	_______	________	Anxiety/Nervousness	______
_______	Seizure/epilepsy	_______	________	Mental retardation	______
_______	Bipolar Disorder	_______	________	Behavior problem	______
_______	Substance Addition	_______	________	Reading problem	______
_______	Attention problems	_______	________	Other learning disorder	______
_______	Autism	_______	________	Developmental delay	______
_______	Cancer	_______	________	Suicide attempt	______
_______	Diabetes	_______	________	Heart trouble	______
_______	Cystic fibrosis	_______	________	High blood pressure	______
_______	Kidney disease	_______	________	Migraine headaches	______
_______	Multiple sclerosis	_______	________	Stroke	______
_______	Tuberculosis	_______	________	Alzheimer's disease	______
_______	Hemophilia	_______	________	Huntington's chorea	______
_______	Muscular Dystrophy	_______	________	Parkinson's disease	______
_______	Sickle-cell anemia	_______	________	Tay-Sachs disease	______
_______	Tourette's syndrome	_______	________	Birth defect	______
_______	Cerebral palsy	_______	________		
_______	Other: Describe____				

.Has anyone in the family ever been in special education services? Yes ________ No_________

If yes, who?_______________________ What type of services?______________________

.Has anyone in the family ever completed suicide? Yes ________ No_________

If yes, who?_______________________ When?__________________________________

.Has anyone in the family ever been hospitalized in a psychiatric facility? Yes ________ No_________

If yes, who?_______________________ When?__________________________________

Educational History

Elementary:____ Dates:_____________

____ Dates:_____________

Middle School:____ Dates:_____________

____ Dates:_____________

High School: ____ Dates:_____________

____ Dates:_____________

University: ____ Dates:_____________

____ Dates:_____________

Current School: ____ Year:______________

Describe your current grades and academic performance.

____

____

Did you ever receive any special education services or accommodations under ADA (e.g., Title I, 504 accommodations, speech/language, adaptive physical education, occupational therapy, classroom aide, etc., accommodations for standardized testing – such as TAKS, SAT)? Yes______ No______

If yes, what type of service(s)?____

Have you been previously evaluated for learning issues?____

If yes, what were the results/diagnoses? (any previous documentation/reports are also requested):

____

____

Have you ever been retained a grade? Yes________ No________

If yes, which grade(s) and why?____

Did you ever receive tutoring or additional assistance for any academic subject: If so, please list subject and type of tutoring (e.g. tutoring center, in-home tutoring, before/after school at school): _________________

____