

ADULT QUESTIONNAIRE

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Instructions: Please fill out this questionnaire as best you can. If you have any questions, please contact my office at 602-274-1462. If it is possible to fax this questionnaire (and the others included in this packet) to my office before the evaluation, that would be helpful. My fax number is 602-274-7402. Regardless of whether you fax these questionnaires, please bring the originals with you to the appointment. Thank you.

Name: _____ Age: _____ Date of Birth: _____

Address: _____

Telephone/e-mail address _____

Date of Evaluation: _____ Who referred you? _____

Are you filling out this questionnaire alone? Yes No (who is helping you? _____)

Will you come alone to the evaluation? Yes No

Who will come with you to the evaluation? _____

Please briefly describe the reason you are receiving this evaluation: _____

MEDICAL HISTORY:

Please list relevant information about your medical history, including major illnesses, injuries, surgeries, and/or hospitalizations.

Medical Event

Date

<u>Medical Event</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever suffered a significant blow to the head or alteration/loss of consciousness?

If Yes, complete the following section No

Please describe the incident(s), including the date(s). _____

Did you lose consciousness? Yes No *If so, how long?* _____

Were you dazed after the injury? Yes No *If so, please explain)* _____

Did this event require hospitalization? Yes No *If Yes, for how long?* _____

Have you ever had MRI, CT, SPECT, or PET scan of the brain? Yes No

If yes, what type(s) of scan? _____

When did you have this scan? _____ Do you know the results? _____

Have you experienced any of the following? Please check yes or no for each item. If yes, give any details or time line in the box to the right. For example, is this problem current or in the past?

		If yes, please give details
Problems with hand motor skills (e.g., coordination, strength, or speed)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems with lifting restrictions	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems walking longer distances	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems standing for very long	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems with your vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems with your hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you wear glasses or contact lenses? Yes No Describe why _____

Have you received any speech therapy, occupational therapy, or physical therapy for your condition?

If Yes, complete the following section No

What therapies did you have? _____ When? _____

Did you find these therapies helpful? Yes No Please explain _____

Are you interested in receiving more therapy? Yes No

DEVELOPMENTAL/SOCIAL HISTORY:

Where were you born? _____ Where were you raised? _____

Do you know of any problems with your pregnancy/birth? Yes No If so, please explain _____

Were there any known developmental delays (e.g., speech/motor skills)? Yes No If so, please explain _____

Which hand do you use most for writing? Right Left Both (Explain _____)

What hand do you use for throwing? _____ What leg do you kick with? _____

Do you have a history of using the other hand when you were younger? Yes No Who lived in your home growing up? _____

Did you get along with your family growing up? Yes No Please explain _____

Did you have problems getting along with your peers as a child Yes No

Did you experience any significant conduct/legal problems as a child or adolescent? Yes No

If so, please explain _____

Have you experienced any legal problems (e.g. arrests) as an adult? Yes No If so, please explain _____

Do you speak any languages beside English? Yes No What was your first language? _____

If your first language isn't English, when did you begin speaking English? _____

What language was primarily spoken in the home growing up? _____

Are you currently in a romantic relationship? Yes No If so, please explain _____

Have you ever been married? Yes No If so, please explain _____

Do you have children? Yes No If Yes, please give the information below:

Name	Age/Gender	Do they live with you?	Do they live close?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any close friends? Yes No Comments _____

Are you close to any family members? Yes No Comments _____

EDUCATIONAL HISTORY:

While you were in school, what were your average grades? (List as A, B, C, D, or F)

School	Completed?	Grade
Elementary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High School	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vocational/Tech School	<input type="checkbox"/> Yes <input type="checkbox"/> No	
College	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Graduate School	<input type="checkbox"/> Yes <input type="checkbox"/> No	
GED	<input type="checkbox"/> Yes <input type="checkbox"/> No	

If you received any degrees/certificates in vocational/tech school or college, list your major and degree/certificate you received _____

Did you ever repeat a grade? Yes No If so, what grade(s) and why? _____

What subject(s) were your strongest? _____

Did you ever experience academic/learning difficulties? Yes No If so, what subjects? (e.g., reading, spelling, writing, math, etc.) _____

Were you ever diagnosed with a learning disability? Yes No

Did you have problems paying attention in school? Yes No Hyperactivity/restlessness? Yes No

Do you know of any delays in beginning school or reading? Yes No

WORK HISTORY:

Are you currently working? Yes No If so, how many hours per week? _____

If you are working, are you having any problems at work? Yes No If so, explain _____

If you are not working, complete this section:

How long have you been out of work? _____

Why did you stop working? _____

Are you planning or wanting to return to work? Yes No *If yes when?* ___/___/___

Please list your current and previous jobs. Begin with the most recent job and work backwards.

Job Title	Type of work	Dates (approximately)	Reason for leaving
		--	
		--	
		--	
		--	
		--	
		--	
		--	

CURRENT STATUS:

What type of home do you live in? _____ Does anyone else live in the home? Yes No

If so, who else lives in the home? _____

Do you currently drive? Yes No If so, do you have any problems with driving? Yes No

If you don't drive, when did you stop driving? _____



Are you planning to return to driving again? Yes No If Yes, when? _____

What are your current sources of income? _____

Do you handle your own finances? Yes No If so, any problems doing so? (explain) _____

Do you have health insurance? Yes No If so, what company? _____

MEDICATIONS:

Please list all prescription medications you are currently using.

Medication	Dosage	How long have you taken this?	If you know, please state the purpose of this medication

Have you had any bad experiences with prescription drugs? _____

ALCOHOL/SUBSTANCE USE:

How often do you drink alcohol?

- Never Rarely Occasionally Daily Weekly Monthly

If you do not drink, when did you last consume alcohol? _____

Have you had problems with alcohol use in the past? _____

Have you ever received treatment for alcohol/substance use? _____

Have you ever used non-prescribed drugs? Yes No If yes, complete this section:

Please list all drugs that you have used with the frequency of use and ages during use:

Do you smoke cigarettes? Yes No If yes, complete this section:

How much do you smoke? _____

For how long have you smoked? _____

PSYCHOLOGICAL HISTORY:

Are you currently receiving counseling/psychotherapy? Yes No

If not, would you be interested in pursuing counseling/psychotherapy? Yes No Maybe

Have you received psychotherapy in the past? Yes No

If yes, did you think it was helpful? Yes No (explain) _____

In the past, have you taken any medications to help with your mood or emotions? Yes No

If yes, did you find it helpful? Yes No (explain) _____

Have you ever been treated by a psychiatrist and given a diagnosis? Yes No Not sure

If yes, please explain _____

Have you ever experienced a hallucination? Yes No Not Sure (explain) _____

How many hours do you sleep each night? _____

Do you sleep well at night? Yes No

What problems do you have with sleeping? Hard to fall asleep Frequently waking up

Waking tired Complete insomnia Frequent nightmares Sleep apnea

For how long have you been sleeping poorly? Recently Since an injury All my life

Have you ever taken prescription sleep medication? (explain) _____

Have you ever taken over-the-counter sleep medication? (explain) _____

For the following items, please rate each domain on a scale of 0 to 10

0 = NO problems at all; and 10 = MAXIMUM problems.

Please rate your memory for recent information, such as important conversations you had recently (0 = NO problems with memory; 10 = severe problems with memory):

0 1 2 3 4 5 6 7 8 9 10

Please rate your ability to remember future appointments (0 = NO problems; 10 = severe problems)

0 1 2 3 4 5 6 7 8 9 10

Please rate your ability to stay organized (0 = NO problems; 10 = severe problems)

0 1 2 3 4 5 6 7 8 9 10

Please rate your ability to concentrate/focus (0 = NO problems; 10 = severe problems):

0 1 2 3 4 5 6 7 8 9 10

Please rate your ability to find the words needed to express yourself (0 = NO problems; 10 = severe problems):

0 1 2 3 4 5 6 7 8 9 10

Please rate your overall fatigue (0 = NO fatigue; 10 = severe fatigue):

0 1 2 3 4 5 6 7 8 9 10

Please rate your overall level of physical pain (0 = NO pain; 10 = severe pain):

0 1 2 3 4 5 6 7 8 9 10

Please rate how irritable you typically feel (0 = NO irritability; 10 = extreme irritability):

0 1 2 3 4 5 6 7 8 9 10

Please rate how depressed you typically feel (0 = feeling quite happy almost all the time; 10 = feeling extremely sad most of the time):

0 1 2 3 4 5 6 7 8 9 10

Please rate how anxious or worried you typically feel (0 = no anxiety or worries; 10 = feeling anxious or worried almost all the time):

0 1 2 3 4 5 6 7 8 9 10

Please rate how frustrated you typically feel (0 = NO frustration; 10 = severe frustration):

0 1 2 3 4 5 6 7 8 9 10

Please rate how angry you typically feel (0 = NO anger; 10 = severe anger):

0 1 2 3 4 5 6 7 8 9 10

Any other important information _____
