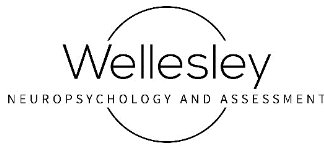

Client History and Information Intake Form

Please make sure to email this form to the clinician appointed to your case and bring a copy in its entirety for your first session. Failure to do so will result in a longer interview process and/or charge for late cancellation and reschedule.

1. DEMOGRAPHIC HISTORY

Name: ___________________________________ Date of Initial Appointment:____________

Gender:__________ Age: __________ DOB:____/____/_____ Handedness: ◻ Right ◻ Left ◻ Ambidextrous

Marital Status: ◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ Widowed ◻ Other____________________

Number of previous marriages: __________ Years of education: ___________________

Address:____

Home Phone:___________________ Office/Cell Phone: ______________________________

Email:____

Referring Provider: ____ Phone: (_____) _________________

Ethnicity: ___________________ Primary Language: ________________________________

Primary reason for appointment/evaluation: ______________________________________

____

____

____

____

____

2. CURRENT PROBLEMS

In your own words, please describe your main concern or problem:_________________________________

Have you noticed any difficulties with your ability to think, remember, concentrate, use language, or deal with spatial problems? □ Yes □ No If yes, please describe:

How long have you experienced this problem, or when did you first notice it?

What stressors may have contributed to the current compliant or problem (such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, financial problems, educational issues, etc.)?

Are there any noticeable compensatory behaviors (behaviors that have developed to cope with current injury/ issue) that have developed due to head injury, stroke, paralysis, mood/anxiety disorder:_________________

____

____

What are your (or the identified client's) strengths and growing edges:

Strengths: ____

____

____

Growing edges: ____

____

____

Are you (or the identified client) experiencing any difficulties with the following:

Attention and Concentration	**None**	**Mild**	**Moderate**	**Severe**	**Comments**
Difficulty concentrating	◻	◻	◻	◻	
Easily Distracted	◻	◻	◻	◻	
Forgetting why walked into room or what task about to start	◻	◻	◻	◻	
Other:	◻	◻	◻	◻	
Learning and Memory	**None**	**Mild**	**Moderate**	**Severe**	**Comments**
Difficulty remembering recent events, names, faces, the date, etc.	◻	◻	◻	◻	
Difficulty learning and remembering new information	◻	◻	◻	◻	
Difficulty recalling things that have recently been told to you	◻	◻	◻	◻	
Forgetting appointments/upcoming events	◻	◻	◻	◻	
Frequently repeating questions/statements/stores	◻	◻	◻	◻	
Other:	◻	◻	◻	◻	
Language	**None**	**Mild**	**Moderate**	**Severe**	**Comments**
Difficulty understanding others or following conversations	◻	◻	◻	◻	
Difficulty understanding what you read	◻	◻	◻	◻	
Forgetting the correct words/names for things	◻	◻	◻	◻	
Speaking less clearly than before	◻	◻	◻	◻	
Changes in writing (less legibly, smaller font, etc.)	◻	◻	◻	◻	
Other:	◻	◻	◻	◻	
Processing Speed	**None**	**Mild**	**Moderate**	**Severe**	**Comments**
Taking longer than expected to complete tasks	◻	◻	◻	◻	
Taking longer to process information or formulate thoughts	◻	◻	◻	◻	
Other:	◻	◻	◻	◻	

Executive Functioning	None	Mild	Moderate	Severe	Comments
Difficulty following multi-step commands/instructions	◻	◻	◻	◻	
Difficulty multitasking	◻	◻	◻	◻	
Difficulty organizing and planning	◻	◻	◻	◻	
Difficulty prioritizing tasks/responsibilities	◻	◻	◻	◻	
Other:	◻	◻	◻	◻	
Perceptual Problems	**None**	**Mild**	**Moderate**	**Severe**	**Comments**
Difficulty reading/following a map	◻	◻	◻	◻	
Difficulty parking your car (e.g., multiple dents, scrapes on car)	◻	◻	◻	◻	
Difficulty recognizing objects	◻	◻	◻	◻	
Other:	◻	◻	◻	◻	
Daily Functioning	**None**	**Mild**	**Moderate**	**Severe**	**Comments**

Difficulty managing money/handling finances	☐	☐	☐	☐	
Forgetting/ missing appointments	☐	☐	☐	☐	
Difficulty managing medications	☐	☐	☐	☐	
Changes in ability to manage household chores	☐	☐	☐	☐	
Becoming lost while driving or walking	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	
Physical Symptoms	**None**	**Mild**	**Moderate**	**Severe**	**Comments**
Problems with coordination	☐	☐	☐	☐	
Weakness	☐	☐	☐	☐	
Numbness	☐	☐	☐	☐	
Clumsiness	☐	☐	☐	☐	
Dizziness	☐	☐	☐	☐	
Changes in taste or smell	☐	☐	☐	☐	
Incontinence	☐	☐	☐	☐	
Frequent Falls	☐	☐	☐	☐	
Tremors	☐	☐	☐	☐	
Poor balance	☐	☐	☐	☐	
Staring spells or fluctuating levels of coherence	☐	☐	☐	☐	
Changes in sleeping pattern, such as sleeping more during the day and difficulty sleeping at night	☐	☐	☐	☐	
Kicking, hitting, yelling, falling out of bed, or acting out dreams while asleep	☐	☐	☐	☐	
Changes in appetite (increased or decreased)	☐	☐	☐	☐	
Changes in weight (increase or decrease)	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	
Changes in Behavior/Personality/Mood	**None**	**Mild**	**Moderate**	**Severe**	**Comments**
Depressed mood/sadness	☐	☐	☐	☐	
Feeling anxious, tense, worried	☐	☐	☐	☐	
Panic attacks	☐	☐	☐	☐	

Large or rapid fluctuations in mood	◻	◻	◻	◻	
Irritability or reduced frustration tolerance	◻	◻	◻	◻	
Anger or difficulty controlling temper	◻	◻	◻	◻	
Thoughts of suicide	◻	◻	◻	◻	
Generating more ideas than usual and/or racing thoughts	◻	◻	◻	◻	
Thoughts most people consider to be strange or bizarre	◻	◻	◻	◻	
Seeing, hearing, smelling, or feeling things that are not there	◻	◻	◻	◻	
Delusions (believing things that are very unlikely to be true)	◻	◻	◻	◻	
Less inhibited, making inappropriate comments	◻	◻	◻	◻	

Accused or believed that others are stealing from them	◻	◻	◻	◻	
Other:	◻	◻	◻	◻	

3. MEDICAL HISTORY: Personal and Family
Please check all that apply to yourself (the identified client) or to immediate family members (e.g., grandparents, parents, siblings, children)

	Clie nt	Family Members (please list members)	Ages/Date of Diagnosis
Essential Tremor	◻	◻ ______________	
Parkinson's Disease	◻	◻ ______________	
Headaches	◻	◻ ______________	
Tumor/Cancer	◻	◻ ______________	
Seizures/epilepsy	◻	◻ ______________	
Multiple Sclerosis	◻	◻ ______________	
Stroke	◻	◻ ______________	
Dementia (Alzheimer's, Vascular, Lewy Body)	◻	◻ ______________	
Concussion/Traumatic Brain Injury	◻	◻ ______________	
Meningitis	◻	◻ ______________	
Hydrocephalus	◻	◻ ______________	
HIV/AIDS	◻	◻ ______________	
Diabetes type I/II	◻	◻ ______________	
High blood pressure/Hypertension	◻	◻ ______________	
High cholesterol/Hyperlipidemia	◻	◻ ______________	
Heart problems (heart attack, arrhythmia)	◻	◻ ______________	
Exposure to toxic chemicals/waste/ pesticides	◻	◻ ______________	
Thyroid disease	◻	◻ ______________	
Sleep apnea	◻	◻ ______________	
Learning difficulties (reading, math, writing)	◻	◻ ______________	

ADD/ADHD	☐	☐ ________________	
Developmental Disorders (e.g., autism spectrum disorder)	☐	☐ ________________	
Substance abuse	☐	☐ ________________	
Other:	☐	☐ ________________	
Other:	☐	☐ ________________	

Current Medication List (include vitamins, supplements, herbs):

Name of Medication	Dosage	Frequency	Prescribing MD	What is it for?

Sleep:

How would you rate your current sleep quality? □ Excellent □ Good □ Fair □ Poor

How many hours do you typically sleep per night? ____________

How many hours did you sleep last night? ____________

Are you currently taking medications to help you sleep? If yes, what? ___________________________________

Please check all that apply to your sleep: □ Snoring □ Gasping/choking □ Acting out your dreams □

Difficulty falling asleep □ Difficulty staying asleep □ Early morning awakening

Do you use a device for sleep apnea? □ Yes □ No

Recent Imaging:

Head CT Date(s): ___________________ Findings: ___________________________________

Brain MRI Date(s): ___________________ Findings: ___________________________________

EEG Date(s): ___________________ Findings: ___________________________________

PET Scan Date(s): ___________________ Findings: ___________________________________

Assessment History:

Previous IQ, Educational, Psychological, or Neuropsychological Testing: ☐ Yes ☐ No
If Yes, Date(s): ____

***If you have the report, please bring it with you to your appointment**

Have you or your child even been identified as having a disability ☐ Yes ☐ No
If yes, by whom, what age, & what disability? ____

4. Psychiatric History: Personal and Family
Please check all that apply to yourself or to immediate family members (e.g., grandparents, parents, siblings, children)

	Client	Family Members (please list members)	Ages/Date of Diagnosis
Depression	☐	☐ ________________________	
Bipolar Disorder	☐	☐ ________________________	
Anxiety	☐	☐ ________________________	
PTSD	☐	☐ ________________________	
Panic Attacks	☐	☐ ________________________	
Schizophrenia	☐	☐ ________________________	
Anger management problems	☐	☐ ________________________	
Suicidal thoughts	☐	☐ ________________________	
Suicide attempt(s)	☐	☐ ________________________	
Alcohol abuse	☐	☐ ________________________	
Other substance abuse	☐	☐ ________________________	
Other:	☐	☐ ________________________	

Please list any hospitalizations that you have had for **psychiatric** reasons:

Date of Hospitalization	Diagnosis/Condition	Treatme nt

Are you currently in psychotherapy/under psychiatric care: ▫ Yes ▫ No

If yes, please describe the type and duration of treatment: ____

____

____

Substance Abuse

Have you ever been treated for alcohol or drug use or abuse? ▫ Yes ▫ No

If yes, which substance(s): ____

Treatment location: __________________________________ Treatment date: _______________________

On average, how many drinks do you consume in a week? _________
What is the most number of drinks you drink a day? ___________

Which alcoholic beverages do you drink? (e.g., beer, wine, liquor): ______________________________________

Have you ever used illicit substances? ▫ Yes ▫ No

If yes, list which ones: ____________________________________

Have you ever felt you ought to cut down on your drinking or drug use? ▫ Yes ▫ No

Have people annoyed you by criticizing your drinking or drug use? ▫ Yes ▫ No

Have you ever felt bad or guilty about your drinking or drug use? ▫ Yes ▫ No Have

you ever had a drink or used drugs first thing in the morning? ▫ Yes ▫ No

5. Education History

How many years of school did you (or the identified client) complete? ________

Please complete the following table with regard to your educational history

	Name and City	Grades (A's, B's, etc.)	Classes or grades failed (if any)	Degree awarded OR years attended
Elementary				
High School				
Technical				

College				
Post College				

Any behavioral, learning, speech, or language problems? ▫ Yes ▫ No
If yes, please describe: ____

____

____

Additionally, did you (or your child) receive specific accommodations at school? ▫ Yes ▫ No
If yes, what accommodations were there and when did they begin?

____

____

How does your child feel about school? ____

How valued is education in the family? ____

About how much time does your child spend on homework each night? _______________________

How much of a struggle is homework? ▫ Not a struggle ▫ Sometimes a struggle ▫ Often a struggle

6. Occupation History

Please list your employment history below

Current/most recent position title: ____

Name of employer: _______________________________ Dates of employment: _____________

Job responsibilities: ____

Previous position title: ____

Reason for leaving: ____

Name of employer: _______________________________ Dates of employment: _____________

Job responsibilities: ____

Previous position title: ____

Reason for leaving: ____

Name of employer: _______________________________ Dates of employment: _____________

Job responsibilities: ____

7. Psychosocial History

Place of birth: ______________________________________ If not U.S., date moved to U.S.: _______________

First Language: _____________________________________ If not English: Age first learned English: ________

What language are you most comfortable with currently? ______________________

Language spoken at home: ____________________________________

Are your biological parents (or the child's) currently: ▫ Married ▫ Separated ▫ Divorced ▫ Never Married

If separated or divorced, who has legal custody? : ▫ Mother/Spouse 1 ▫ Father/Spouse 2 ▫ Other (specify):

____

If separated or divorced, how do you feel you (or the identified client) has adjusted to separation or divorce?

____

Mother's Highest Level of Education: ________ Occupation:_______________________________________

Father's Highest Level of Education: __________ Occupation:______________________________________

If married, Spouse's Highest Level of Education: ____________ Occupation: _________________________

Please list all immediate family & nonfamily members that have a significant relationship with you (or your child):

Name	**Relationship to child**	**Age / Grade**	**Living in house?**

Please list all locations (city, state) that you (or your child) have lived:

Birthplace	Moved at age / grade

	Moved at age / grade
	Moved at age / grade
	Moved at age / grade
	Moved at age / grade
	Moved at age / grade
	Moved at age / grade

Military History

If you have any military history, please specify below:

Branch: ______________________ Dates of service: _______________ Highest Rank: _____________________

Honorable discharge? ▫ Yes ▫ No

Types of duties performed: ____

8. Litigation

Are you involved in ongoing litigation, disability evaluation, or worker's compensation cases?
If so, please explain the nature of the case(s) below: ____

____

____

____

____

____

9. Developmental History

Is your child your: ◻ biological child ◻ adopted child ◻ foster child ◻ other: ________________________

Mother's age at birth? ____________ Did mother receive routine medical prenatal care ◻ Yes ◻ No

Please specify any medications used during pregnancy and the reason used: ___________________________
____

Pregnancy lasted _________ weeks/months Child's birth weight: _______ pounds ________ ounces

Please check the conditions below that describe the health of the child and mother during pregnancy

Mother's Pregnancy	Child's Delivery	Child's Condition at Birth
◻ No complications	◻ Normal	◻ No complications
◻ Blackouts	◻ Induced Labor	◻ Lack of Oxygen
◻ Falls	◻ C-Section	◻ Breathing Problems
◻ Physical Injury	◻ Breech birth	◻ Birth Injury
◻ Excessive Bleeding	◻ Unusually long labor (>12 hours)	◻ Jaundice
◻ Hypertension	◻ Premature # of weeks ____________	◻ Stunned at birth
◻ Diabetes	◻ Overdue # of weeks ______________	◻ Newborn ICU # of days ________
◻ Emotional Stress	◻ Other Problem (Specify) ______________________________ ______________________________ ______________________________ ______	◻ Other Problem (Specify) _________________________ _________________________ _________________________ ______
◻ Toxemia	◻	◻
◻ Alcohol/Drug Use	◻	◻
◻ Use of Tobacco	◻	◻

Early Childhood Behavior

Newborn Phase: During your (or the identified client's) first few years of life, were any of the following present?

◻ Difficult to Comfort	◻ Difficulty nursing
◻ Was not easily calmed by being held or stroked	◻ Poor eye contact

☐ Colicky	☐ Did not respond to their name
☐ Excessive irritability	☐ Fascination with certain objects
☐ Diminished sleep	☐ Constantly head banging

If you checked any of the above, please describe ____
____
____

Milestones: Please indicate age or age range when your child preformed the following milestones:

Milestone	0-3 Months	4-6 Months	7-12 Months	13-18 Months	19-24 Months	2-3 Years	3-4 Years
Sat up without help							
Crawled							
Walked							
Spoke first words							
Spoke sentences							
Fully potty trained							
Stayed dry all night							

Child's Early Temperament: (Toddler through five years of age)

Activity Level – How active has your child been from an early age? ___________________________________
____

Distractibility – How well was your child able to maintain focus or concentrate on tasks? _______________
____

Adaptability – How well was your child able to deal with transition, change, or when denied their own way?
____
____

Mood – What was your child's basic mood? Did they exhibit frequent mood changes? __________________
____

Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.? ____________
____

Prior to age 6, did your child have more difficulty than other children his/her/their age doing the following:

▫ Sitting still at mealtime	▫ Staying focused on TV, movies, tablets, etc.
▫ Paying attention when read to	▫ Waiting for their turn at play
▫ Throwing / catching a ball	▫ Knowing left and right
▫ Buttoning and zipping	▫ Dressing self
▫ Holding crayons or pencils	▫ Tying shoelaces
▫ Accidently dropping/knocking things over	

How often are each of the following settings a problem for your child?

Activity	**Rarel y**	**Sometimes**	**Frequentl y**
While getting ready for school	▫	▫	▫
When playing alone	▫	▫	▫
When with a babysitter or at daycare	▫	▫	▫
When in the car	▫	▫	▫
When watching TV/tablet or playing games	▫	▫	▫

Current Behavioral Description of Your Child

How would you describe your child's personality at home? ____
____
____
____

Which adult would your child prefer to talk with about a problem? ___________________________________

To whom is the family member that your child feels closest? ____

Who is primarily responsible for discipline/evoke behavior change at home? ___________________________

What are the most effective ways to cope with your child's challenging behaviors at home? _____________
____

____
____

Describe the type of discipline that occurs in the household ___________________________________
____

List any responsibilities your child has at home: ____
____

List your child's wake time ___________________ Bedtime _____________________________________

List your child's favorite hobbies and interests: ____
____
____
____

How would you describe your child's peer relationships? _______________________________________
____
____
____