Client Questionnaire

Your completion of this form will greatly help in understanding you and your concerns. This is confidential information and will not be released without written permission from you. It is useful in understanding the questions to be answered by the evaluation and may be referred to in the written report. If extra space is needed, please feel free to attach additional pages for your comments.

Date: _____

Person(s) filling out this form: Client _____ Other _____

I. IDENTIFYING DATA

Client's Name _____ Sex _____ Age _____

Date of Birth _____ Handedness _____ Ethnicity _____

Client currently lives with _____

at _____
(address, city, state, zip)

_____ _____ _____
(area code & home phone number) (cell phone number) (e-mail address)

Referred by _____

Other specialists consulted: Name _____ Date _____

Agency _____ City _____

Their findings/recommendations _____

Please send copies of all test/evaluation reports

PURPOSE OF THIS EVALUATION:

What questions would you like answered by this evaluation? _____

_____

_____

My strengths include _____

_____

I believe my main problem(s) to be _____

_____

_____

For whom is the report intended (e.g., myself, present school, future school, physicians, etc.)?

_____

II. DEVELOPMENTAL HISTORY

A. Were you adopted? _____ If yes, age at time of adoption _____

B. Mother's medical history during pregnancy:

You were which of the total number of pregnancies (1st, 2nd, etc.)? _____

When did your mother's prenatal care begin? _____

Was your mother treated for any of the following? (Give the approximate month of pregnancy)

1. Convulsions _____
2. Infections _____
   a. Virus _____
   b. Measles _____
   c. Hepatitis _____
   d. Toxemia _____
   e. Other _____
3. What medications were taken during pregnancy? _____
   When? _____
4. Were the following factors present during your mother's pregnancy?
   a. Pelvic irradiation _____
   b. Unusual nutritional factors _____
   c. Uterine abnormalities _____
   d. RH incompatibility _____
   e. Bleeding _____ When? _____ Duration _____
   f. Accidents during pregnancy _____
   g. Emotional pressures during pregnancy (describe briefly) _____

_____

III. OBSTETRICAL HISTORY FOR THIS CLIENT

Where were you born _____

Length of mother's pregnancy _____

Length of mother's labor (approximate hours) _____

Spontaneous? _____ Induced? _____

Delivery:

a. By planned or unplanned Cesarean section? _____

b. If placed in NICU, for how long? _____

f. Weight at birth _____lbs., _____oz.

IV. DEVELOPMENTAL HISTORY

Behavior	Age Accomplished	Comments About the Achievement
sat unsupported		
walked unattended		
first words spoken		
talked clearly enough that strangers understood		

V. MEDICAL HISTORY

If you have had any of the following, give approximate age if actual age is not remembered.

Mumps _____ Measles _____ Chicken Pox _____ Meningitis _____

Frequent headaches _____ Hearing problems _____ Stomach upsets _____

Frequent colds _____ Whooping Cough _____ Hay Fever _____

Ear infections _____ Highest temperature _____

Allergies to _____

Comments _____

_____

_____

Past Medical History

What illness have you had in the past other than usual childhood illness? (high fever, asthma, diabetes, high blood pressure, medical conditions)

_____

_____

Accidents or injuries in the past? (loss of consciousness, concussions, broken bones, head injury, car accidents, sports injuries, back injuries) When did injuries occur?

Have you ever been treated or evaluated by a psychologist, counselor, social worker, psychiatrist, etc.? Explain symptoms, diagnosis(es), any suicidal thoughts or attempts?

What type of prescription meds to you take? _____

Tobacco use (type, how much)? _____

Alcohol use (type, how much)? _____

Do you use any recreational drugs? (marijuana, cocaine) Was there ever a time when you used a lot of drugs? How long since you last used any drugs?

VI. FAMILY HISTORY

Please include parents, step-parents, full, half, and step siblings.

Family of Origin

Name/Relation	Age	Health Problems	Occupation	Highest Grade Completed	Grade Repeated	Learning Problems

With whom did you live during childhood and adolescence? _____

Any abuse experienced? (physical or sexual) _____

Present health of immediate family members _____

_____

_____

Your marital status: _____

_____

_____

List by name the members of your nuclear family (e.g., spouse, children, etc.)

Name of Family Member	**Relationship to You**	**Age**	**Highest Year of School Completed**	**Name Any Grade Repeated**	**Reading, Writing, Math or Speech/ Language Problems? If so, which and when?**

Previous marriages? Yes _____ No_____ Dates of marriages and divorces: _____

_____

Please note a history of the following illnesses/difficulties (cousins, aunts, uncles, and grandparents, as well as immediate family members, are to be included):

Illness/Difficulty	Check if Yes	When Occurred	Relationship (e.g., maternal aunt)
Convulsive Seizures			
Autism Spectrum Disorders			
Mental Retardation			
Drug Addiction			
Criminal Record			
Depression			
Bipolar Disorder			
Psychotic Disorder/ Schizophrenia			
Anxiety Disorders			
Articulation			
Deafness			
Reading, Writing, Spelling Problems (note which)			
Mathematics Difficulty			
Hyperactivity			
Attention Problems			

VII. SCHOOL HISTORY

I. List the names of schools attended beginning with kindergarten through high school: Indicate if you repeated a grade or had entry into kindergarten or first grade delayed.

School Name	Client's Age	Grade	City/State	School System (public/private)

II. Post High School: Certificate/License/Diploma

Name of School	Years Attended	GPA	Earned	Major

Did you ever fail or repeat a grade? Explain

Were you ever in special education, remedial classes or require tutoring? Explain

What were your best subjects?

What were your most difficult subjects?

If you quit high school or college before graduating, what were the reasons?

Did you have trouble paying attention? Yes _____ No _____

Did you have difficulty working independently? Yes _____ No _____

Did you have special help at school? Yes _____ No _____

If so, what type (e.g., tutoring, speech therapy, resource room), when and for how long? Please describe.

Vocational History

Years Employed	Company	Position	Reason for Leaving

VIII. BEHAVIOR

Reported Problems Client is Presently Experiencing

Yes or No		Explain
_____	Memory	_____
_____	Sense of Touch	_____
_____	Hearing	_____
_____	Language Comprehension	_____
_____	Word Finding	_____
_____	Reading	_____
_____	Writing	_____
_____	Arithmetic	_____
_____	Intellectual (problem solving, etc.)	_____
_____	Sleep	_____
_____	Appetite	_____
_____	Personality	_____
_____	Sexual	_____
_____	Activity Level	_____
_____	Concentration	_____
_____	Depression	_____
_____	Mood Changes	_____
_____	Anxiety/Nervousness	_____
_____	Hallucinations	_____
_____	Patience	_____
_____	Temper/Impulse Control	_____
_____	Speech	_____
_____	Difficulty Walking	_____
_____	Coordination	_____
_____	Headaches	_____
_____	Dizziness	_____
_____	Seizures	_____
_____	Interpersonal Relations	_____
_____	Other	_____

Primary source of income _____

Future goals _____

As a youth, did you ever have contact with the police or juvenile authorities? If so, please explain.

_____

_____

Leisure Activities/Interpersonal Relationships

What leisure activities do you participate in with your family or others? _____

_____

Do you have any hobbies or leisure interests? _____

_____

If not married, are you currently dating? _____

Describe how you get along with:

Father _____

Mother _____

Brothers _____

Sisters _____

Spouse _____

Children _____

Others in home _____

Comments _____

Who are the important people in your life? (close or important relationships)

_____

_____

Are you the kind of person who has a lot of friends or a few close friends or the kind to keep to yourself and your family?

_____

_____

_____

What type of things have caused you stress in the past year?

_____

_____

_____

Any additional information you feel will be helpful to us may be written below or on a separate sheet.