Twin State Psychological Associates

Excellence with Compassion for Over 40 Years

Mailing Address: 29 Ridgewood Rd., Springfield, VT 05156
Phone: 802-885-5719

Adult Intake Information Form

Please bring this completed questionnaire with you at the time of your first appointment. Thank you.

Patient's Name _____ Date _____ Phone: _____

Address _____ Email: _____
City/Town State

Date of Birth_____ Age _____ (Circle One) Right Handed, or Left Handed, or Ambidextrous?

Who referred you to Twin State Psychological Services? _____

Marital Status: Married ____ Divorced ____ Never Married ____ Other _____

If Married, Length of Current Marriage: _____ Number of Times Married: _____

Partner's Name: _____ Age: ___ Education: _____ Occupation: _____

Ages of Children:

Problems Seeking Consultation For and Relevant History

- Briefly describe what problems (symptoms) you have had that led to this referral:

- Approximate date when these problems began: _____. Did your problems begin abruptly or gradually?

- To the best of your knowledge, what are the causes of these problems?

Overall Health: Please rate your overall health at this time: Poor Fair Good Excellent

Mood: Please describe your mood at this time:

Medication	**Dosage**	**Reason Taking?**	**How Long Taken?**	**Side Effects (if any)**

Previous psychological, psychiatric or neurological evaluation and/or treatment:

Approximate Date	Provider	Nature of Problem

Please indicate whether you have any of the following problems:

1. Problems with your **memory** for information you've heard or seen or for things that have happened to you: Yes No If yes, please describe: _____
_____
_____

2. Problems with **understanding what you are told or what you read**: Yes No If yes, please describe: _____
_____
_____

3. Problems with **finding words when you are speaking or writing:** Yes No If yes, please describe: _____
_____

4. Difficulty with sustaining your **attention**: Yes No If yes, please describe: _____
_____
_____

5. Circle any of the following areas where you have problems: **impulse control, organization skills, planning, decision making, judgment, flexibility, or concentration:** Please describe: _____
_____
_____

6. Circle any of the following areas where you have problems: **finding you way around, getting lost, misjudging distances and bumping into things?** Please describe: _____
_____
_____

7. Circle any of the following areas where you have problems: **coordination, balance, physical weakness especially if only on one side of your body:** Please describe: _____
_____
_____

8. Circle any of the following areas where you have problems: **sight, hearing, taste, smell, numbness or other sensory phenomena:** Please describe: _____
_____
_____

9. Problems with **pain:** Yes No If yes, please describe: _____
_____
_____

10. Problems with **reading, math or writing:** Yes No If yes, please describe: _____
_____
_____

11. Circle any of the following areas where you have problems: **Eating, bathing, dressing, toileting, walk, continence; Cooking, cleaning, laundry, taking medications, managing money, shopping, using transportation, using computer/phone**. Please describe: _____
_____
_____

Please indicate whether you or a family member have had any of the following health problems:

	Self	Family Member (Relation)
Attention		
Learning Disabilities		
Depression		
Bipolar		
Anxiety		
Phobias		
Obsessions/ Compulsions		
Delusions		
Hallucinations		
Suicidal Thoughts/Behavior		
Homicidal Thoughts/Behavior		
Schizophrenia		
Alzheimer's Disease		
Other Dementia		
Parkinson's Disease		
Multiple Sclerosis		
Stroke		
Sleep Problems		
Appetite		
High Blood Pressure		
Heart Disease		
Lung Disease		
Cancer/Tumor		
Diabetes		
Exposure to Toxic Substances		
Lyme Disease		
Other Medical Problems		
Seizures/Epilepsy		
Head Injury*		
Other Loss of Consciousness		

* For any head injury *you* have had, please indicate below:

Approximate Date Occurred? How it occurred? Loss of Consciousness? If LOC, for how long?

_____

_____

Trauma History: Have you been exposed to a traumatic event(s), including **physical, sexual or emotional or verbal abuse**, which involved actual or threatened serious psychological or physical injury to yourself or another close to you? Yes No If yes, please briefly describe:

- do you have thoughts or flashbacks of the traumatic event(s)? Yes No
- do you attempt to avoid thinking about the traumatic event(s))? Yes No
- do you startle easily? Yes No

Family History of Alcohol & Substance Abuse: Does your family have a history of alcohol or non-prescribed drug abuse? If so, please describe:

On average, how much **alcohol** (beer, wine, liquor) do you drink a week? _____
Have you ever had a period when you **excessively drank alcohol**? If so, from what age to what age?

Have you ever had a period when you excessively used **non-prescription drugs?** If so, which non-prescription drugs did you use and from what age to what age?

Have you received **treatment for alcohol or chemical dependency**? If so, at what age and where?

Have you ever used **tobacco**? If so, what type of tobacco, how much and how long?

Have you ever had an extensive exposure to **chemicals** in your life?

Legal Problems: Describe any legal problems you have/have had?

Disability: Have you applied for, or are you currently receiving, **disability compensation** as a result of current or past illness or injury? If yes, please specify disability and type of compensation:

Are you currently involved in or planning **legal action** related to the illness/injury for which you are being evaluated? If yes, please describe:

Recreational Activities: What recreational activities do you participate in?

Developmental, Educational & Occupational History

1. Number of siblings: Ages:
2. Parents' marital status:
3. Father's occupation and education:
4. Mother's occupation and education:
5. Describe what growing up in your family was like: _____
   _____
6. Describe any problems with your Mother's pregnancy with you or your birth?
7. Did your mother smoke or use alcohol or drugs during her pregnancy with you?
8. How was your memory in childhood? Excellent _____ Good _____ Fair _____ Poor _____
9. As a child, how did you learn best? Reading ___ Hearing information ___ Observing ___
10. How many years of formal education did you complete? _____
11. Name of school *last* attended: _____
12. Please describe your attitude toward school:
13. Did you ever repeat any grades? If so, which grade(s)?
14. Were you, or family members ever thought to have Learning Disabilities? If so, what type?
15. Did you receive Special Education Services?
16. If taken and known, please provide any standardized test (SAT, GRE etc.) scores.
17. In the table below, please provide information regarding your work history:

Occupation	Approx. Dates (From/To)	Title/Duties

18. Have your problems affected your ability to do your job? Your social life? If retired or unemployed, has it affected your ability to perform daily activities? Please describe:
19. Does your present work or daily activities satisfy you?

Thank You