

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.

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

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:

<i>Illness / Operation</i>	<i>Age</i>
_____	_____
_____	_____
_____	_____

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.

<i>Date Started</i>	<i>Date Stopped</i>	<i>Medication</i>	<i>Dose</i>	<i>Response</i>	<i>Reason for Medication</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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"**).

<i>Check if yes</i>	<i>Condition</i>	<i>Relationship to child</i>	<i>Check if yes</i>	<i>Condition</i>	<i>Relationship to child</i>
_____	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): _____

