SHARED VISION
PSYCHOLOGICAL SERVICES
Building Healthy Connections

THE ASSESSMENT CLINIC
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ADULT NEUROPSYCHOLOGICAL INTERVIEW

INSTRUCTIONS: To provide a greater understanding of your concerns, please fill in the blanks or check the correct answers. Please answer as thoughtfully and frankly as possible, since this information will provide some direction on how we might address your concerns. All information is regarded as confidential. If you have difficulty with any of the questions, please leave them blank for now. Thank you for taking the time to complete this form.

Name:_____ **Date:**_____

Address:_____

_____ **Phone:**_____

Date of Birth:_____ **Race/Ethnicity:**_____

Sex / Gender:_____ **Handedness** ❑Left ❑Right

REFERRAL INFORMATION

Referral Source:_____

Relationship:_____

Address:_____

Phone:_____

Reason for Referral

What are your primary concerns? _____

What questions would you like answered? _____

How long have these problems been occurring? _____

Have there been any significant changes or stressors in your life during the last year?
☐Yes ☐No If yes, please describe: _____

PRIOR PSYCHOLOGICAL TREATMENT/ASSESSMENT

Have you ever had educational or psychological testing?* ☐Yes ☐No
If yes, who performed the testing? _____ When was it performed? _____
If yes, please provide a copy of the results.

Have you ever had inpatient or outpatient psychological treatment such as individual, group, or family psychotherapy, counseling, or an intensive inpatient program?

Date	Place	Level of Care	Outcome

EARLY CHILDHOOD HISTORY

General Information:

If you were raised in foster or adoptive care, do you have knowledge or documents regarding your medical history? ☐No ☐Yes

Where were you born? (hospital, city, state) _____

Were you born: Early by 1 week or more? ❑No ❑Yes -- If so, how early? _____

Overdue by one week or more? ■No ❑Yes If so, how overdue? _____

Method of birth: ■Normal delivery ❑Breech (feet first) ❑Caesarian section

If C-section: ❑Planned ❑Emergency

Pregnancy/Birth Information

Were there any problems or complications during pregnancy or delivery? ☐ Yes ☐ No

Check any of the following that apply:

❑ Accident	❑ Anemia	❑ Preeclampsia, eclampsia, or toxemia
❑ Bleeding	❑ Diabetes	❑ High blood pressure
❑ Illness	❑ Surgery	❑ Psychological problems or stress
❑ Fetal distress	❑ Excess vomiting	❑ Premature placenta separation

Did the mother take medication or have an X-ray during pregnancy? ☐ Yes ☐No

Did the mother drink alcohol during the pregnancy? ☐ Yes ☐ No

If so, how much?_____ How often?_____

Did the mother use cocaine or any other drugs during pregnancy? ☐ Yes ☐No

Did the mother smoke cigarettes during the pregnancy? ☐Yes ☐ No

Was labor induced? ☐ Yes ☐ No

If yes, with what was it induced? _____

Was the mother in labor over 24 hours? ☐ Yes ☐No

Did the mother's water break over 24 hours before delivery? ☐ Yes ❑ No

Did the mother have any postpartum complications? ❑ Yes ☐No

How many pregnancies had the mother had? _____

Were there any miscarriages? ☐ Yes ☐ No How many? _____

Were there any stillbirths? ☐Yes ☐ No How many? _____

What was your birthweight? _____lbs. _____oz.

How often did the mother see the doctor during her pregnancy?_____

How much time passed before the mother realized she was pregnant? _____ weeks.

At what age did you first leave the hospital? _____

Initial complications: ❑Jaundice ❑Respiratory problems

Treatment: _____

_____

Infant problems

As an infant, did you have any of the following problems? Check those that apply.

❑ Feeding trouble	❑ Colic	❑ Excess vomiting
❑ Constipation	❑ Blueness (cyanosis)	❑ Seizure (convulsions)
❑ Need for oxygen	❑ Breathing trouble	❑ Yellow jaundice
❑ High fever	❑ Excessive diarrhea	❑ Head banging
❑ Slow weight gain	❑ Stiffness	❑ Chronic ear infections
❑ Excess irritability	❑ Congenital defect	❑ Heart disease/defect

❑ Hydrocephalus ❑ Bleeding into brain ❑ Physical abnormality

What kind of milk were you started on? ❑Breast ❑Formula
How old were you when you were weaned from the bottle or breast? _____Months

DEVELOPMENTAL HISTORY

Developmental Milestones

Did you first sit without help between the ages of 4-8 month?	❑Yes	❑No
Did you first walk alone between 9-18 months?	❑Yes	❑No
Did you follow simple commands between 12-18 months?	❑Yes	❑No
Did you use simple sentences between 18-30 months?	❑Yes	❑No
Did you first learn to ride a tricycle between 2-4 years of age?	❑Yes	❑No
Did you first learn to ride a bicycle between 5-6 years of age?	❑Yes	❑No

Temperament

Describe your early temperament. Check all that apply.

Activity level	❑ Low	❑ Average	❑ High
Sleeping/eating schedule	❑ Predictable	❑ In-between	❑ Unpredictable
Unfamiliar situations	❑ Inhibited/cautious	❑ In-between	❑ Uninhibited
Concentration	❑ Low	❑ Average	❑ High
Social	❑ Very shy, timid	❑ Average	❑ Very friendly
Persistence with activities	❑ Very persistent	❑ Average	❑ Gave up quickly
Sensitivity to sound	❑ Sensitive	❑ Average	❑ Not sensitive at all
Sensitivity to touch	❑ Sensitive	❑ Average	❑ Not sensitive at all
Sensitivity to light	❑ Sensitive	❑ Average	❑ Not sensitive at all
Sensitivity to taste, smell	❑ Sensitive	❑ Average	❑ Not sensitive at all
Intensity	❑ Calm	❑ Average	❑ Emotional
Mood	❑ Happy	❑ Average	❑ Irritable, unhappy

EDUCATIONAL HISTORY

Preschool/Background

Did you attend preschool? ❑Yes ❑No If yes, at what age?_____
Describe any problems _____
What age did you enter 1st grade? _____ If later than six, why?_____

*Academic Achi*evement

Highest grade achieved_____
Name of high school_____
Name of college _____
Please check the item that best describe your CURRENT grades:
❑ Superior ❑ Above average ❑ Average ❑ Below average ❑ Failing
Please check the item that best describes your grades THROUGHOUT your school experience:
❑ Superior ❑ Above average ❑ Average ❑ Below average ❑ Failing
Have you repeated any grades/classes? ❑ Yes ❑ No If yes, which grade(s)_____
Have you skipped any grades? ❑ Yes ❑ No If yes, which grade(s)_____
Did you ever take the ACTs or SATs in high school? ❑No ❑Yes
If yes, what were your scores? _____

Has your school ever reported problems with the following (check all that apply)?

- ❑ Reading letters and words:_____
- ❑ Reading Comprehension:_____
- ❑ Spelling:_____
- ❑ Writing:_____
- ❑ Math:_____
- ❑ Social Studies:_____
- ❑ Science:_____
- ❑ Following Directions:_____
- ❑ Other:_____

School Services

Have you ever received special services at school? ❑Yes ❑No

If yes, please check all that apply:

- ❑ Speech and language
- ❑ Self-contained classroom
- ❑ Occupational therapy
- ❑ Support for learning disability
- ❑ Social work
- ❑ Physical therapy

Previous Diagnoses

Have you ever been diagnosed with any of the following? Please check all that apply:

- ❑ Reading learning disability
- ❑ Spelling learning disability
- ❑ Nonverbal learning disability
- ❑ Receptive language disorder
- ❑ Asperger's disorder
- ❑ ADHD
- ❑ Written expression learning disability
- ❑ Math language learning disability
- ❑ Expressive language disorder
- ❑ Autism
- ❑ Pervasive developmental disorder
- ❑ Other _____

MEDICAL HISTORY

Illness

Check any of the following illnesses that you have had:

- ❑ Measles
- ❑ Mumps
- ❑ Losing consciousness
- ❑ Fainting spells
- ❑ Excess fatigue
- ❑ Ear infections
- ❑ Rheumatid arthritis
- ❑ Blood in urine
- ❑ Urinary/kidney infections
- ❑ Head injury
- ❑ Poisoning
- ❑ Sleep apnea
- ❑ Whooping cough
- ❑ Pneumonia
- ❑ Asthma
- ❑ Easy bruising
- ❑ Worms (intestinal)
- ❑ Seizures
- ❑ Exposure to TB
- ❑ Chicken pox
- ❑ German measles
- ❑ High blood pressure
- ❑ Blood transfusion
- ❑ Anemia
- ❑ Broken bones
- ❑ Skin problems
- ❑ Binge eating
- ❑ Self-induced vomiting or laxative abuse
- ❑ Nausea/vomiting/diarrhea>72 hours
- ❑ Unintentional weight loss (>5 lbs. per month)
- ❑ Other serious illness:_____

If yes to any, types of treatments:_____

Medications

Are you taking any medications? ❑ Yes (Please list below) ❑ No

Name	Dosage	Frequency

Have you been on previous medications? ❑ Yes (Please list below) ❑ No

Hospitalizations

Have you ever been hospitalized at any time? ❑ Yes (Please list below) ❑ No

Age	Year	Hospital	Reason

EMPLOYMENT HISTORY

Are you working at this time? ☐ Yes ☐ No

Current place of employment: _____

Job title & description of duties: _____

_____

Additional work history:

Type of employment	Length of employment

Are you experiencing problems or difficulties at work? ☐ Yes ☐ No

If so, what kind of difficulties are you experiencing and for how long? _____

_____

Have you ever lost a job, been discharged from the military, etc? ☐ Yes ☐ No

If yes, please describe. _____

BEHAVIORAL/SOCIAL HISTORY

Home or Community Problems

How are things going at home? Any problems? ☐ Yes ☐ No

Any legal problems or problems in the community? ☐ Yes ☐ No
If so, for how long and describe the nature of the problem(s)?

Energy Level/Functioning

Are there time when you feel very tired? ☐ Yes ☐ No Very hyper? ☐ Yes ☐ No
Are there times when you have been more tired/hyper? ☐ Yes ☐ No
If so, does this get in the way of your doing activities or chores, and for how long?

Family/Social Relationships

How do you get along with your family? _____

Do you feel you have friends who support and help you when you have problems? ☐ Yes ☐ No
Do you get in a lot of fights? ☐ Yes ☐ No
If so, with whom? _____

Parenting Problems

Do you have any children? ☐ Yes ☐ No
If yes, do you have custody of them? ☐ Yes ☐ No
Any difficulties taking care of them? ☐ Yes ☐ No
If yes, please describe: _____

ADLs (Daily activities)

Have you had any problems lately doing the things you need to do on a daily basis to take care of yourself or have you had less motivation to complete them?: ☐ Yes ☐ No
If yes, how? _____

Financial Problems

Any current money problems? ☐ Yes ☐ No
If yes, in what way(s), is it causing stress, and for how long? _____

Behavioral Changes

Would people you know well say your behavior has recently changed in any way, or have you noticed changes in your behavior? ☐ Yes ☐ No

If yes, what are these changes and how long has this been going on? _____

_____

Sleeping

❑Not sleeping ❑Increased Sleep ❑Difficulty going to sleep

❑Early morning awakening ❑Periodic awakening

Describe: _____

_____

Average hours of sleep per night _____

Nightmares? ❑ Yes ❑ No If yes, describe _____

Appetite

❑ Normal ❑ Overweight ❑ Bingeing ❑ Excessive exercising

❑ Poor ❑ Very thin ❑ Purging

Please describe anything checked above: _____

_____

❑Weight loss ❑Weight gain Amount _____ Time Frame: _____

Anxiety

❑ Nervousness/Worry ❑ Excessive Fear ❑ Obsessions

❑ Panic Attacks ❑ Phobias ❑ Compulsions

Please describe: _____

Psychosis

❑ Hallucinations ❑ Auditory ❑ Olfactory ❑ Delusions

❑ Visual ❑ Tactile ❑ Command

Please describe (How often, intensity, when, etc.): _____

Abuse

❑ Emotional: Perpetrator(s): _____ When _____

❑ Physical: Perpetrator(s): _____ When _____

❑ Sexual: Perpetrator(s): _____ When _____

❑ Domestic: Perpetrator(s): _____ When _____

Substance Abuse

❑ Marijuana ❑ Alcohol ❑ Tobacco

❑ Hallucinogens ❑ Inhalants ❑ Prescriptions

❑ Cocaine ❑ Heroin ❑ Pain Killers

❑ Opiates ❑ Hallucinogens ❑ Cocaine
❑ Other _____

Substance	Age at 1st Use	Amounts/Patterns of Use	Last Use	Route

AA/NA attendance history _____
Periods of abstinence _____
Family substance use _____

Current Living Situation

❑ Apartment ❑ With Relatives ❑ Dormitory
❑ House ❑ Nursing Home
❑ Homeless ❑ Group Home
Living with (relationship, ages) _____

Marital History _____
Children _____
Family support network includes _____
Sexual orientation _____
Has current illness affected family support? ☐Yes ☐No
If so, please describe: _____

Current Social Situation

Current activities/group memberships _____
Religious preference _____ Regularly attends service? ☐Yes ☐No
Has current illness affected social network and/or spirituality? Please describe _____

Legal History and Status

❑ None ❑ Parole ❑ Police Involvement
❑ Probation ❑ Court Involvement
Please describe: _____

Problem Checklist

Check off any problems listed below that apply to you. Check "New" if this is a new problem (within the past year). Check "Old" if this is a problem that has persisted for longer than one year.

PROBLEM SOLVING

Do you experience difficulty with:	**New**	**Old**
Learning new or complex activities or concepts		
Organizing activities, job work, or personal items at home		
Solving problems another adult can do		
Understanding explanations		
Benefiting from experiences (makes same errors repeatedly)		

Varying play/recreation activities or problem solving strategies		
Switching from one activity to another (transitions)		
Completing an activity in a reasonable amount of time		
Containing frustration (tends to give up easily)		
Other:		

LANGUAGE

Do you experience problems with:	**Old**	**New**
Articulation ❑Omits sounds ❑Substitutes sounds ❑Distorts sounds		
Fluency		
Speaking in a monotone (very little emotion in speech)		
Talking more than average		
Odd or unusual language or vocal sounds		
Understanding what others are saying		
Other:		

ACADEMIC SKILLS

Rate each skill compared to other adults your age:	**Old**	**New**
Reading letters and words		
Reading comprehension		
Writing letters (correct form, proper orientation)		
Spelling		
Math: ❑Written math ❑Mental calculations ❑Word problems		

Needs more time than others to complete work ❑Yes ❑No
Difficulty with homework ❑Yes ❑No
Difficulty with school seemed to begin (age/grade): _____

NONVERBAL SKILLS

Do you experience difficulty with:	**Old**	**New**
Puzzles, blocks, or similar games		
Direction (right/left) or orientation (back/front or up/down)		
Drawing or copying		
Identifying colors or color blindness		
Recognizing objects or people the adult should know		
Dressing (tying shoes, pulling up zipper) not due to physical disability		
Other:		

Are you much better with: ❑ Language than hands-on activities
❑ Hands-on activities than language

ATTENTION

Do you experience problems with:	Old	New
Mind appears to go blank at a time, or loses train of thought		
Difficulty paying attention: ❑At work ❑At home ❑Socializing with friends		
Becoming easily distracted		
Other:		

Problems with attention seemed to start around age: _____

Attention problems seem to improve with the following activities: _____

_____

MEMORY AND LEARNING

Do you frequently forget:	Old	New
Where you leave work assignments or other objects		
What happened recently (e.g. prior meal)		
What happened days or weeks ago		
School or work assignment		
What you have been told recently		

Can you recognize something even if you cannot recall it? ❑Yes ❑No

You are best at remembering: _____

MOTOR AND COORDINATION

Do you experience the following:	Old	New
Muscle weakness or paralysis ❑Left ❑Right		
Muscle tightness or spasticity ❑Left ❑Right		
Clumsy or awkward ❑Left ❑Right		
Walking, gait problems ❑Left ❑Right		
Odd movements (posturing, peculiar hand movements, etc.)		
Involuntary or repetitive movements: ❑Eye/facial ❑Vocal ❑Limbs ❑Body		
Oral (mouth) motor problems		
Poor fine motor skills (e.g., using a pencil, scissors, etc.)		
Other motor or coordination problems		

SENSORY

Do you experience the following:	Old	New
Vision problems ❑Left ❑Right		
Hearing problems ❑Left ❑Right		
Loss of feeling on skin ❑Left ❑Right		
Difficulty smelling or tasting food		
Overly sensitive to: ❑Touch ❑Light ❑Noise		
Other sensory problems:		

BEHAVIORS

Do you experience any of the following:	Old	New

Aggression toward people, animals, or property		
Bizarre or unusual behavior		
Craving or eating of non-food substances		
Immature or dependent for your age		
Eating habits that are poor or unusual		
Fear or nervousness		
Headaches		
Noncompliance with rules		
Impulsivity or disinhibition		
Inappropriate sexual behavior		
Lying		
Low self-esteem		
Nausea		
Nail biting		
Nightmares		
Poor social skills		
Repetitive behaviors		
Risky (dangerous) behaviors		
Stomach aches		
Suicidal acts or statements		
Withdrawl or isolation from people		

FAMILY HISTORY

Immediate Family

RELATIONSHIP	NAME/ AGE	EDUCATION/ OCCUPATION	SPECIAL PROBLEMS	LIVING WITH PATIENT
Parent/guardian (circle role)				☐ Yes ☐ No
Parent/guardian (circle role)				☐ Yes ☐ No
Sibling				☐ Yes ☐ No
Sibling				☐ Yes ☐ No
Sibling				☐ Yes ☐ No
Other/Specify				☐ Yes ☐ No
Other/Specify				☐ Yes ☐ No

If parents are married, what year did they marry? _____

If separated or divorced, provide date: _____

Has either parent remarried? If yes, please describe: _____

_____

Previously Diagnosed Family Disorders

Please check any of the following conditions that have occurred in the patient's family:

CONDITION	FATHER	MOTHER	FATHER'S FAMILY	MOTHER'S FAMILY	SIBLINGS
ADHD					
Brain or neurological disease					
Developmental delay					
Epilepsy or seizure					
Genetic disorder					
Learning disorder					
Mental retardation					
Schizophrenia					
Bipolar disorder					
Anxiety disorder					
Panic disorder					
Obsessive-compulsive disorder					
Depressive disorder					
Speech and language disorder					
Other:					

PHYSICIAN INFORMATION

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Are there any other things that we did not ask, or that you want us to know about you that might help in understanding you?:

Additional Notes:_____

Thank you for your time in completing this form. This information is very valuable to the assessment process and will be used to help guide your evaluation.