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: _____

FAMILY HISTORY

Immediate Family

RELATIONSHIP	NAME/ AGE	EDUCATION/ OCCUPATION	SPECIAL PROBLEMS	LIVING WITH PATIENT
☐ Parent/ ☐ Guardian				☐ Yes ☐No
☐ Parent/ ☐ Guardian				☐ 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: _____

_____

BEHAVIORAL/SOCIAL HISTORY

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_____
Are you currently in need of any community resources or social services? ☐Yes ☐No
If so, please describe: _____

Current Social Situation

Current activities/group memberships _____
Religious preference _____ Regularly attends service? ☐Yes ☐ No

Legal History and Status

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

_____

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)?

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?

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?

Pregnancy/Birth Information

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

If so, please describe:

_____

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 birthing parent take medication or have an X-ray during pregnancy? ☐ Yes ☐ No

Did the birthing parent drink alcohol during the pregnancy? ☐ Yes ☐ No

If so, how much? How often?

Did the birthing parent use cocaine or any other recreational drugs during pregnancy? ☐ Yes ☐ No

Did the birthing parent smoke cigarettes during the pregnancy? ☐ Yes ☐ No

Was labor induced? ☐ Yes ☐ No

If yes, with what was it induced?

What was your birthweight? lbs. oz.

Did you require a NICU stay following birth? If so, please describe:

_____

_____

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

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

Were you ever identified by a medical professional as eligible for early intervention services? If so, please describe:

_____

_____

_____

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

MEDICAL HISTORY

Illness

Check any of the following illnesses that you have had:

☐ Measles	☐ Head injury	☐ Exposure to TB
☐ Mumps	☐ Poisoning	☐ Chicken pox
☐ Losing consciousness	☐ Sleep apnea	☐ German measles
☐ Fainting spells	☐ Whooping cough	☐ High blood pressure
☐ Excess fatigue	☐ Pneumonia	☐ Blood transfusion
☐ Ear infections	☐ Asthma	☐ Anemia
☐ Rheumatoid arthritis	☐ Easy bruising	☐ Broken bones
☐ Blood in urine	☐ Worms (intestinal)	☐ Skin problems
☐ Urinary/kidney infections	☐ Seizures	☐ 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

Who prescribes these medications?

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

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

Previously Diagnosed Family Disorders

Please check any of the following conditions that have occurred in your family:

CONDITION	FATHER	MOTHER	FATHER'S FAMILY	MOTHER'S FAMILY	SIBLINGS
ADHD	☐	☐	☐	☐	☐
Brain or neurological disease	☐	☐	☐	☐	☐
Developmental delay	☐	☐	☐	☐	☐
Epilepsy or seizure	☐	☐	☐	☐	☐

CONDITION	FATHER	MOTHER	FATHER'S FAMILY	MOTHER'S FAMILY	SIBLINGS
Genetic disorder	☐	☐	☐	☐	☐
Learning disorder	☐	☐	☐	☐	☐
Intellectual disability	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Bipolar disorder	☐	☐	☐	☐	☐
Anxiety disorder	☐	☐	☐	☐	☐
Panic disorder	☐	☐	☐	☐	☐
Obsessive-compulsive disorder	☐	☐	☐	☐	☐
Depressive disorder	☐	☐	☐	☐	☐
Speech and language disorder	☐	☐	☐	☐	☐
Other:					

Energy Level/Functioning

Has there ever been a time when you were able to stay up for several nights and not feel tired the next day?

☐ Yes ☐ No

If yes, please 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	☐ Inhalants	☐ Pain Killers
☐ Hallucinogens	☐ Heroin	☐ Opiates
☐ Cocaine	☐ Tobacco	☐ Hallucinogens
☐ Alcohol	☐ Prescriptions	☐ Cocaine

☐ Other _____

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

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

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 degree achieved:

- ☐ Less than high school
- ☐ High school diploma
- ☐ Some college
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate or other professional degree

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 ☐ Co-taught classroom

☐ Self-contained classroom ☐ Social work

☐ Occupational therapy ☐ Physical therapy

Did you hold an IEP or 504 plan at any point in your schooling? If so, what accommodations were helpful for you?

_____

_____

Previous Diagnoses

Have you ever been diagnosed with any of the following?

Please check all that apply:

☐ Reading learning disability ☐ Written expression learning disability

☐ Spelling learning disability ☐ Math language learning disability

☐ Nonverbal learning disability ☐ Expressive language disorder

☐ Receptive language disorder ☐ Autism

☐ ADHD ☐ Other _____

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. _____

_____

_____

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:	**Old**	**New**
Learning new or complex activities or concepts	☐	☐
Organizing activities, job work, or personal items at home	☐	☐
Solving problems another adult can do	☐	☐
Understanding explanations	☐	☐
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	☐	☐
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	☐	☐

Need 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	☐	☐
Withdrawal or isolation from people	☐	☐

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.