



ADULT CLINICAL INTERVIEW

Participant Name: _____ **Date:** _____

Address: _____

Phone: (Home) _____ (Cell) _____

Birth Date: _____ Age: _____ Sex: _____ Dominant Hand: _____

Birth Place: _____

Marital Status: _____ Occupation: _____

Race: _____ Ethnic Identity: _____

Primary Language: _____ Secondary Language: _____

Physical Disabilities: _____

Current Living situation: _____

PRESENTING SYMPTOMS (Why are you here Today?)

FAMILY HISTORY

Answer the following questions with regard to your **biological** parents and siblings.

Mother

Education: _____ Occupation: _____

Learning Disorders: ___ No ___ Yes - Describe: _____

Health history: _____

Mental health history: _____

Father

Education: _____ Occupation: _____

Learning Disorders: ___ No ___ Yes - Describe: _____

Health history: _____

Mental health history: _____

Siblings

How many brothers and sisters do you have? _____ Brothers _____ Sisters Your - birth order? _____

Do any of your brothers or sisters have physical, academic, or psychological problems? ___ No ___ Yes

Describe: _____

Who raised you (check all relevant answers):

___ Biological parents ___ First degree relatives ___ Foster parents

___ Biological & step parents ___ Adoptive parents ___ Institutional setting

___ Others - Who? _____

Please check any of the following characteristics close biological family members had, and describe problem:

Condition	Person and type/severity	Condition	Person and type/severity
___ Epilepsy/seizures	_____	___ Alcoholism	_____
___ Learning disability	_____	___ Drug abuse of any kind	_____
___ Left-handedness	_____	___ Manic-depression (bipolar)	_____
___ Mental retardation	_____	___ Depression	_____
___ Alzheimer's disease	_____	___ Personality disorder	_____
___ Huntington's disease	_____	___ Schizophrenia	_____
___ Multiple sclerosis	_____	___ Other psychiatric disorder	_____
___ Parkinson's disease	_____	___ Speech or language disorder	_____
___ Other neurological disease	_____	___ Other major disease	_____

NAME _____

BIRTH DETAILS

On the following chart, please mark if any of the following apply for the period of time FROM YOUR CONCEPTION TO DELIVERY, and if so, how often. If you wish to add anything or make comments, please do so below the chart or in the comments section at the end of the questionnaire. (Please note that not everything on this list is a problem)

Did your mother use/experience/participate in ...	Never	1 to 3 times during conception or pregnancy	More than 3 times, but not with any regularity (such as once per month)*	Fairly Often	Almost Always	Always	Don't Know
Prenatal vitamins							
Birth control*							
Prescribed medications*							
Other drug or medication not prescribed*							
Alcohol (any amount or form)							
Smoking (herself or in proximity)							

*** Please specify below if this box is marked**

Comments or clarifications of the above: _____

Any complications during labor and delivery? NO or YES _____

Birth weight (if known) _____ Length (if known) _____

Did any of the following conditions impact you during delivery or in the first few days afterwards?	YES	NO	DON'T KNOW	Comments
Injured during delivery				
Cardiopulmonary distress				
Delivered with cord around neck				
Had trouble breathing after delivery				
Needed oxygen				
Required being placed in an incubator				
Turned blue (was cyanotic)				
Turned yellow (was jaundiced)				
Had an infection				
Had seizures				
Was given medications for any purpose				
Born with a congenital birth defect				
Hospitalized for more than 7 days				

EARLY INFANCY

Were you told as an infant you were	YES	NO	Comments
Difficult to feed			
Difficult to get to sleep			
Colicky			

NAME _____

Easy to comfort			
Difficult to put on a schedule			
Difficult to keep busy			
Alert			
Cheerful			
Affectionate			
Sociable			
Overly active			
Stubborn, challenging			
Easy going			

CHILDHOOD AND ADOLESCENT BEHAVIOR AND DEVELOPMENT

At what about what age did you:

Crawl _____ Walk _____ Talk _____ Toilet Trained _____

Were you ever told that you had any developmental delay? NO YES - please elaborate: _____

Before age seven, would you describe yourself as or were you described by others as:

- | | | | | | |
|--------------|-----|----|------------------|-----|----|
| 1. Shy | YES | NO | 5. High strung | YES | NO |
| 2. Quiet | YES | NO | 6. Overly active | YES | NO |
| 3. Withdrawn | YES | NO | 7. Clumsy | YES | NO |
| 4. Anxious | YES | NO | 8. Messy | YES | NO |

Before the age of seven would you think that others would say that you, as a general rule you:

- | | | | | | |
|---|-----|----|------------------------------------|-----|----|
| 1. Don't pay attention to details | YES | NO | 10. Fidget | YES | NO |
| 2. Don't pay attention as long as needed | YES | NO | 11. Have trouble sitting still | YES | NO |
| 3. Don't seem to listen | YES | NO | 12. Run around all the time | YES | NO |
| 4. Don't finish things | YES | NO | 13. Have trouble playing quietly | YES | NO |
| 5. Can't organize things | YES | NO | 14. Talk a lot | YES | NO |
| 6. Avoid things that take a lot of effort | YES | NO | 15. Blur out answers to questions | YES | NO |
| 7. Lose things | YES | NO | 16. Have trouble waiting your turn | YES | NO |
| 8. Are easily distracted | YES | NO | 17. Interrupt others | YES | NO |
| 9. Forget things | YES | NO | 18. Don't mind your own business | YES | NO |

Would you describe yourself as a child as, generally:

- | | | | | | |
|----------------------------------|-----|----|---------------------------|-----|----|
| 1. Not doing what adults request | YES | NO | 4. Being an very shy | YES | NO |
| 2. Acting like a bully | YES | NO | 5. Being an very outgoing | YES | NO |
| 3. Being excessively emotional | YES | NO | | | |

As a child were you told or do you think that you:

- | | | | |
|--|-----|----|-------------------------------|
| 1. Were down or depressed? | YES | NO | How long did this last? _____ |
| 2. Needed to do several things in a ritualistic way? | YES | NO | How long did this last? _____ |
| 3. Worried excessively about many things? | YES | NO | How long did this last? _____ |
| 4. Had a bladder accidents? | YES | NO | How many times? _____ |
| 5. Had bowel accidents? | YES | NO | How many times? _____ |
| 6. Were cruel to animals? | YES | NO | How many times? _____ |
| 7. Set fires when not asked? | YES | NO | How many times? _____ |
| 8. Were anxious when family rituals are disrupted? | YES | NO | How long did this last? _____ |
| 9. Had ideas that others thought were unusual? | YES | NO | How long did this last? _____ |
| 10. Avoided going to public places? | YES | NO | How long did this last? _____ |
| 11. Claimed to be ill before going to school? | YES | NO | How many times? _____ |
| 12. Had trouble getting thoughts out of your head? | YES | NO | How long did this last? _____ |
| 13. Had trouble falling asleep/staying asleep? | YES | NO | How many times? _____ |
| 14. Had fine motor problems? | YES | NO | How long did this last? _____ |
| 15. Unusual changes in appetite? | YES | NO | How long did this last? _____ |

Details of above if needed: _____

NAME _____

As a child or adult were you, to the best of your knowledge, ever:

- | | | | | | |
|---|-----|----|---------------------------------|-----|----|
| 1. A victim of a violent crime? | YES | NO | 4. Physically hurt by an adult? | YES | NO |
| 2. A victim of any crime? | YES | NO | 5. Sexually molested? | YES | NO |
| 3. Been in a place where your life was at risk? | YES | NO | 6. Traumatized in any way? | YES | NO |

If so, please use the space below (or additional pages) to elaborate _____

MEDICAL HISTORY

Date of last physical exam _____ Date next exam is scheduled _____

Have you ever been diagnosed with or told you have had:

- | | | | | | |
|---------------------------|-----|----|--------------------------------------|-----|----|
| 1. Asthma | YES | NO | 11. Broken bones | YES | NO |
| 2. Allergies | YES | NO | 12. Fevers over 104F | YES | NO |
| 3. Diabetes | YES | NO | 13. Heart or blood pressure problems | YES | NO |
| 4. Arthritis | YES | NO | 14. Head injury | YES | NO |
| 5. Chronic illness | YES | NO | 15. Loss of consciousness | YES | NO |
| 6. Epilepsy/Seizures | YES | NO | 16. Lead poisoning | YES | NO |
| 7. Non-epileptic seizures | YES | NO | 17. Surgery | YES | NO |
| 8. HIV Infection/AIDS | YES | NO | 18. Lengthy hospitalizations | YES | NO |
| 9. Chicken Pox | YES | NO | 19. Chronic ear infections | YES | NO |
| 10. Hepatitis | YES | NO | 20. Tropical Disease | YES | NO |

Do you have any other medical conditions not already marked above? YES NO

If you marked YES to any of the above please elaborate: _____

Do you have/have you ever had a mental health diagnosis? _____

Do you currently have any mental health related symptoms? _____

Describe the reasons and durations of all the hospitalizations you have had:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Please describe ALL loss of consciousness, concussion, head injury or other head trauma:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Have you ever had prior psychological or neuropsychological evaluation? ___ No ___ Yes - If yes:

Date(s) of evaluation: _____

Reason(s) for evaluation: _____

Result(s) of evaluation: _____

What, if any, prescribed medication(s) do you take on regular basis? (Use additional pages if needed)

Name of medication	How much (mg)	How often (Once per day, twice, three times)

Do you participate in/use alternative medical treatments such as herbs, chiropractic etc? YES NO

If so, please specify which ones and condition(s) for which seek treatment: _____

NAME _____

Has any parent, sibling or biological child been diagnosed with any mental health condition? YES NO

Relationship	Type of Problem	Any Treatment (Yes or No)	Type of Treatment	Comments

Has any other BIOLOGICAL relative been diagnosed with a mental health condition? YES NO

Relationship	Type of Problem	Any Treatment (Yes or No)	Type of Treatment	Comments

EDUCATION

Were you ever diagnosed with a learning disorder, placed in a special education or pulled out of the regular classroom for special services? NO YES If YES, please elaborate: _____

Highest level of education?: _____ Highest Degree? _____ Year Earned _____

Please list all formal schooling you have had/Degrees you have earned:

Ages	Grades/Degree	Name of School	Location	Public or Private?

SPORTS

Please list all sports activities participated in, starting with your earliest activity (from childhood to present).

Ages	Sport	Any injuries	Head trauma/loss of consciousness?

MILITARY HISTORY

Branch _____ From _____ to _____ Highest Rank Achieved _____

Duties _____

Branch _____ From _____ to _____ Highest Rank Achieved _____

Duties _____

RECREATION

Briefly describe the kinds of things you do for fun or recreation (games, TV, hobbies, books attending church, etc.):

CURRENT SYMPTOM CHECKLIST

Check the space next to every symptom that applies to you and whether it is new (within the last 6 months) or old (lasting longer than 6 months)

1) PROBLEM SOLVING

- | New | Old | |
|-----|-----|---|
| ___ | ___ | Difficulty planning ahead. |
| ___ | ___ | Difficulty figuring out problems that most other people can figure out. |
| ___ | ___ | Difficulty thinking as quickly as needed. |
| ___ | ___ | Difficulty doing things in the right order (sequencing things correctly). |
| ___ | ___ | Difficulty verbally describing the steps involved in doing something. |
| ___ | ___ | Difficulty changing a plan or activity when needed. |
| ___ | ___ | Difficulty completing an activity in a reasonable amount of time. |
| ___ | ___ | Difficulty doing more than one thing at a time. |
| ___ | ___ | Difficulty switching from one activity to another. |
| ___ | ___ | Difficulty knowing when to stop doing something. |
| ___ | ___ | Becoming easily frustrated. |
| ___ | ___ | Tending to easily give up doing something. |
| ___ | ___ | Other problem solving difficulties: _____ |

2) SPEECH, LANGUAGE, AND MATH SKILLS

- | New | Old | |
|-----|-----|--|
| ___ | ___ | Difficulty finding the right word to say. |
| ___ | ___ | Difficulty understanding what others are saying (not because of hearing problems). |
| ___ | ___ | Difficulty speaking at all - unable to speak |
| ___ | ___ | Difficulty staying with one idea while talking. |
| ___ | ___ | Difficulty writing letters or words (not because of motor problems). |
| ___ | ___ | Slurred speech or difficulty articulating words. |
| ___ | ___ | Odd or unusual speech sounds. |
| ___ | ___ | Difficulty with math skills (adding numbers, balancing checkbooks, making change). |
| ___ | ___ | Difficulty understanding what you read. |
| ___ | ___ | Difficulty spelling words. |
| ___ | ___ | Other speech, language, or math problems: _____ |

3) NONVERBAL SKILLS

- | New | Old | |
|-----|-----|---|
| ___ | ___ | Difficulty telling right from left. |
| ___ | ___ | Difficulty doing things you should be able to do automatically (brush teeth, shave, etc). |
| ___ | ___ | Difficulty drawing or copying figures or pictures. |
| ___ | ___ | Difficulty dressing correctly (not due to motor or orthopedic problems). |
| ___ | ___ | Problems finding your way around familiar places. |
| ___ | ___ | Difficulty recognizing objects or people. |
| ___ | ___ | Feeling that parts of your body do not belong to you. |
| ___ | ___ | Unaware of things on one side of your body: Left Side _____ Right Side _____ |
| ___ | ___ | Declines in your musical abilities/preferences. |
| ___ | ___ | Difficulty telling time or knowing what day or season it is. |
| ___ | ___ | Slowed reaction time, clumsiness, uncertainty in movement. |
| ___ | ___ | Difficulty arranging things on order, or putting them away correctly. |
| ___ | ___ | Other nonverbal problems: _____ |

4) CONCENTRATION, ATTENTION, AND AWARENESS

New	Old	
___	___	Highly distractible.
___	___	Losing your train of thought easily.
___	___	Trouble concentrating.
___	___	Becoming easily confused or disoriented.
___	___	Having blackout spells (or fainting).
___	___	Blanking (suddenly realizing you don't remember what went on for the previous few minutes)
___	___	Experiencing auras (strange feelings or sensations - seeing lights of halos, hearing odd sounds; roaring, ringing; smelling odd smells; burning tar).
___	___	Not feeling very alert or aware of things.
___	___	Not feelings very "present" or "on top" of things.
___	___	Feeling sleepy or detached from what is going on.
___	___	Other concentration of awareness problems: _____

5) MEMORY

New	Old	
___	___	Forgetting where you left things (keys, gloves, etc.)
___	___	Forgetting names of people you just meet.
___	___	Forgetting names of people you already know.
___	___	Forgetting what you should be doing, or why you are doing something already.
___	___	Forgetting where you are going.
___	___	Forgetting recent events (TV show, last meal).
___	___	Forgetting events that happened long ago (months or years ago)
___	___	Needing someone to give you a hint to remember things.
___	___	Relying on notes more and more to remember things.
___	___	Forgetting the order things happened in (while cooking, making things)
___	___	Forgetting facts, but knowing how to do things.
___	___	Forgetting faces of people you know (when they are not around).
___	___	Frequently forgetting appointments.
___	___	Forgetting what time it is.
___	___	Forgetting where you are.
___	___	Forgetting things you like (to eat, to do, to go to)
___	___	Other memory problems: _____

6) MOTOR AND COORDINATION

New	Old		Left	Right	Both
___	___	Fine motor control problems (writing, using keys, etc.).	___	___	___
___	___	Weakness on one side of your body.	___	___	___
___	___	Difficulty holding things.	___	___	___
___	___	Tremor or shakiness.	___	___	___
___	___	Muscle tics or twitches.	___	___	___
___	___	Bumping into things a lot	___	___	___
___	___	Writing becomes very small.			
___	___	Writing becomes very large.			
___	___	Writing becomes very shaky and unsteady.			
___	___	Walking is slower than that of other people.			
___	___	Walking is unsteady or uncertain.			
___	___	Having balance or coordination problems.			

NAME _____

- ___ ___ When you close your eyes you feel dizzy or fall down.
- ___ ___ Difficulty starting to move (initiation problem).
- ___ ___ Jerky movements, movement is not at all smooth and supple.
- ___ ___ Tiring quickly, losing strength.
- ___ ___ Tripping or falling easily.
- ___ ___ Difficulty walking on uneven ground or across the face of a hill.
- ___ ___ Other motor or coordination problems: _____

7) SENSORY AND PERCEPTUAL

- | New | Old | | |
|-----|-----|---|-----------|
| ___ | ___ | Loss of feeling or numbness in one or more body parts. | |
| ___ | ___ | Tingling or strange skin sensations in one or more body parts. | |
| ___ | ___ | Difficulty telling hot from cold. | |
| ___ | ___ | Problems seeing things to your left or right. | R___ L___ |
| ___ | ___ | Blurred vision or vision that accommodates slowly. | |
| ___ | ___ | Blank or blind spots in your visual field. | |
| ___ | ___ | Brief periods of blindness. | |
| ___ | ___ | Seeing Stars" or flashes of light. | |
| ___ | ___ | Double vision. | |
| ___ | ___ | Seeing "spangly" shapes that grow with time and make it hard to see. | |
| ___ | ___ | Difficulty looking quickly from one object to another. | |
| ___ | ___ | Needing to squint or move closer to an object to see it clearly. | |
| ___ | ___ | Losing hearing, or feeling that people are not talking loud enough. | |
| ___ | ___ | Ringing in the ears or hearing strange sounds (rumbling, buzzing, etc.) | |
| ___ | ___ | Having difficulty telling how foods taste. | |
| ___ | ___ | Having difficulty telling how things smell. | |
| ___ | ___ | Smelling strange odors. | |
| ___ | ___ | Other sensory problems: _____ | |

8) PHYSICAL SYMPTOMS and BEHAVIORAL CONCERNS

- | New | Old | |
|-----|-----|--|
| ___ | ___ | Headaches Describe _____ |
| ___ | ___ | Dizziness |
| ___ | ___ | Nausea or vomiting. |
| ___ | ___ | Difficulty starting, stopping urine flow, or incontinence. |
| ___ | ___ | Constipation or loss of bowel control. |
| ___ | ___ | Excessive fatigue in spite of wanting to do things. |
| ___ | ___ | Poor motivation or not wanting to do things. |
| ___ | ___ | Low frustration tolerance, very short temper. |
| ___ | ___ | Outbursts of temper or anger. |
| ___ | ___ | Outbursts of crying. |
| ___ | ___ | Panic attacks or feelings of overwhelming anxiety. |
| ___ | ___ | Overwhelming feelings of sadness or depression. |
| ___ | ___ | Difficulty falling asleep, staying asleep, or waking too early (circle one). |
| ___ | ___ | Doing things automatically (without being aware you=re doing them). |
| ___ | ___ | Becoming less inhibited, more spontaneous. |
| ___ | ___ | Being socially inappropriate, self centered, or impulsive. |
| ___ | ___ | Changes in sleep, eating, or sexual interest. Describe: _____ |
| ___ | ___ | Other physical or emotional symptoms: _____ |

there is: ___ Definitely something wrong with me. ___ Possibly something wrong with me ___ Nothing wrong with me