

Hook Psychological Services, PLLC

2505 South 17th St., Suite 200

Wilmington, NC 28401

(910) 254-4545

We are excited that we will be working with you soon. Prior to your upcoming appointment, we have several forms we would like for you to complete.

The following forms are included within this packet:

1. Background History Form
2. Wender Utah Rating Scale
3. Billing/Insurance Paperwork

Please **complete and return** these forms to the following address *as soon as possible*:

Attention: Intake
Potentials
2505 South 17th St., Suite 200
Wilmington, NC 28401

If any questions or concerns arise as you complete these forms, please to call our office staff at **910-254-4545**.

We look forward to seeing you soon!

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Wilmington, NC 28401

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Background Information- Adult Form

The purpose of this questionnaire is to gather information before your appointment. Do not worry if you do not have information to answer every question, as we will be discussing this further at your appointment. We appreciate your time and effort in completing this questionnaire.

Date: _____ Person(s) Completing Form: _____

Referred By: _____

Client Identification

Name: _____ Date of Birth: _____

(First)

(Middle)

(Last)

(Nickname)

Address: _____

(Mailing Address)

City

State

Zip Code

(Street Address)

City

State

Zip Code

Home Phone _____ Work Phone _____

Email Address _____

Reason for Appointment

Who recommended or referred you for this appointment? _____

What question(s) or concern(s) would you like addressed/answered? _____

Do you worry that your problem(s) keep you from achieving your desired potential? Yes No

If yes, please explain _____

What do you feel led to/caused these concerns? _____

When did you first notice these concerns? _____

How do these concerns interfere with your day to day functioning? _____

Check any of the things below that you have trouble doing:

READING

- Reading signs
- Reading labels
- Reading directions
- Reading “how to do” books
- Reading newspapers
- Reading textbooks
- Reading aloud

MATH

- Addition/subtraction
- Multiplication/division
- Making change
- Checkbook
- Math I use at work
- Word problems
- Algebra
- Math above algebra

LISTENING

- To oral directions
- To Lectures
- On the telephone
- With background noise
- Following conversation

WRITING

- Simple messages
- Personal letters
- Filling out forms
- Writing for my job
- Punctuation/spelling
- Essays
- Reports

DIRECTIONAL CONFUSION

- Left/Right
- Confused in a new building
- Get lost much of the time
- Trouble following directions to get somewhere
- Lose my place in reading
- Don’t know where to start filling in forms
- Words seem to swim

MEMORY

- Remembering names
- Details read
- Main ideas read
- Telephone numbers
- Numbers in general
- What I just heard
- What I just saw
- Events long ago
- Material I have studied

Developmental History

How old was your mother when she had you? _____

Were there any problems with your mother’s pregnancy with you? Yes No

If yes, please state _____

Were there any problems associated with her delivery of you? Yes No

If yes, please state _____

Did you have any delays in your early development (e.g., walking, talking)? Yes No

If yes, please state _____

Please check any of the following that you have had significant difficulty with during your lifetime:

	Preschool	Elementary School	Middle School	High School	Post High School
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Decoding Words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Preschool	Elementary School	Middle School	High School	Post High School
Listening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding Oral Directions or Questions Stated by Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remember Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Studying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making/Keeping Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Did you have any serious medical problems as a child? Yes No

If yes, please state _____

Have you received any diagnoses that are developmental (e.g., ADHD, Learning Disability) or psychological (e.g., anxiety, depression) in nature? Yes No

If yes, please state _____

Name of Physician _____

My health is considered: OK Adequate Very Good Excellent

Major Illnesses/Hospitalizations: _____

Please list any medications you are currently taking:

Medication:	Amount:	Reason:	Prescribed by:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychological History:

Are you currently under the care of a psychologist or psychiatrist? Yes No

Have you been seen for a psychological evaluation before? Yes No

If yes, when? _____ By whom? _____

Educational History

What schools have you attended? (please list in chronological order beginning with elementary school)

What is the highest grade/educational level you have completed? _____

Do you like to attend school/take classes? Yes No

Did you ever repeat a grade or course? Yes No

If yes, which one(s)? _____

Did you ever receive extra help or accommodations in school? Yes No

If yes, please check when you received assistance and describe what assistance was provided:

Type of Assistance Received (e.g., tutoring, extra time, counseling, resource)

- Elementary School _____
- Middle School _____
- High School _____
- College _____
- Graduate School _____

Employment History

Are you currently employed? Yes No

If yes, what is your current occupation? _____

Have you ever experienced difficulty with your work, either at your current job or in the past? Yes No

If yes, please briefly describe the type(s) of problem(s) _____

Personal History

Please check one of the following to describe your current relationship status:

- Single
- In a committed relationship
- Married
- Separated
- Divorced

Do you have children? Yes No

If yes, how many? _____

Have there been any significant changes/stresses in your family/home within the past year or so? Yes No

If yes, please describe: _____

What hobbies/interests/activities do you enjoy? _____

Family Medical, Emotional, and Learning History

Please check to indicate if your *biological* family members have had the following conditions:

Condition	Immediate Family				Father's Relatives		Mother's Relatives	
	Dad of Client	Mom of Client	Siblings of Client	Children of Client	Dad	Mom	Dad	Mom
Down Syndrome								
Autism								
Mental Retardation								
Learning Difficulties								
Reading								
Written Language								
Mathematics								
Oral Language								
Hydrocephalus								
Language/Speech Delay								
Hyperactivity								
Attention Deficit								
Conduct Problems								
Drug/Alcohol Abuse								
Neurological Disorders								
Epilepsy/Seizures								
Tics								
Depression								
Anxiety								
Panic Attacks								
Obsessive-Compulsive Disorder (OCD)								
Diabetes or Hypoglycemia								
Hearing Loss								
Vision Problems								
Held back in school								
Muscular problems/weakness								
Other: _____								

WENDER UTAH RATING SCALE (WURS)

Client's Name: _____

DOB _____

Date: _____

<u>AS A CHILD I WAS (OR HAD):</u>	Not at all or very slightly	Mildly	Moderately	Quite a bit	Very Much
1. Active, restless, always on the go					
2. Afraid of things					
3. Concentration problems, easily distracted					
4. Anxious, worrying					
5. Nervous, fidgety					
6. Inattentive, daydreaming					
7. Hot or short tempered, low boiling point					
8. Shy, sensitive					
9. Temper outbursts, tantrums					
10. Trouble stick-to-it-tiveness, not following through, failing to finish things started					
11. Stubborn, strong willed					
12. Sad or blue, depressed, unhappy					
13. Uncautious, dare-devilish, involved in pranks					
14. Not getting a kick out of things, dissatisfied with life					
15. Disobedient with parents, rebellious, sassy					
16. Low opinion of myself					
17. Irritable					
18. Outgoing, friendly, enjoy company of people					
19. Sloppy, disorganized					
20. Moody, have ups and downs					
21. Feel angry					
22. Have friends, popular					
23. Well organized, tidy, neat					
24. Acting without thinking, impulsive					
25. Tend to be immature					
26. Feel guilty, regretful					
27. Lose control of myself					
28. Tend to be or act irrational					
29. Unpopular with other children, didn't keep friends for long, didn't get along with other children					

WENDER UTAH RATING SCALE (WURS) Continued...

<u>AS A CHILD I WAS (OR HAD):</u>	Not at all or very slightly	Mildly	Moderately	Quite a bit	Very Much
30. Poorly coordinated, did not participate in sports					
31. Afraid of losing control of self					
32. Well coordinated, picked first in games					
33. (for women only) Tomboyish					
34. Ran away from home					
35. Get in fights					
36. Teased other children					
37. Leader, bossy					
38. Difficulty getting awake					
39. Follower, lead around too much					
40. Trouble seeing things from someone else's point of view					
41. Trouble with authorities, trouble with school, visits to principal's office					
42. Trouble with the police, booked, convicted					
<u>MEDICAL PROBLEMS AS A CHILD:</u>					
43. Headaches					
44. Stomachaches					
45. Constipation					
46. Diarrhea					
47. Food allergies					
48. Other allergies					
49. Bedwetting					
<u>AS A CHILD IN SCHOOL:</u>					
50. Overall a good student, fast					
51. Overall a poor student, slow learner					
52. Slow reader					
53. Slow in learning to read					
54. Trouble reversing letters					
55. Problems with spelling					
56. Trouble with mathematics or numbers					
57. Bad handwriting					
58. Though I could read pretty well, I never really enjoyed reading					
59. Did not achieve up to potential					
60. Repeated grades (which grades?)					
61. Suspended or expelled (which grades?)					

Adapted from Wender, P. H. (1995). *Attention-Deficit Hyperactivity Disorder in Adults*. New York: Oxford University Press.