Hook Psychological Services, PLLC
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(910) 254-4545

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	□	□	□	□	□
Impulsivity	□	□	□	□	□
Aggression	□	□	□	□	□
Behavior Problems	□	□	□	□	□
Anxiety	□	□	□	□	□
Depression	□	□	□	□	□
Attention Difficulties	□	□	□	□	□
Learning Difficulty	□	□	□	□	□
Difficulty Decoding Words	□	□	□	□	□
Reading Comprehension	□	□	□	□	□
Writing	□	□	□	□	□
Math	□	□	□	□	□

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

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:

	Immediate Family				Father's Relatives		Mother's Relatives	
Condition	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: _____								

Additional Comments (If needed, please attach additional paper.)