Alyson L. Aviv, Ph.D.
Licensed Psychologist
989 GardenView Office Parkway
Saint Louis, MO, 63141
Tel: (314) 591-5564
Fax: (888) 820-9236
Email: alysonaviv@yahoo.com

Comprehensive Intake Questionnaire for Adult Evaluations (18+)

This questionnaire will help me best understand your current difficulties as well as your past history. Please fill out this questionnaire to the best of your ability **before** your intake appointment and bring it with you. Read the questions carefully and answer them as fully as possible (use the reverse side of the paper if necessary). If there are questions that you don't understand, please mark them with a star (*) and Dr. Aviv will review them with you at the intake appointment. Some of these questions will necessitate information gathering from your parents. If you are unable to obtain this information, don't worry!

Personal Information

Date: _____

Name _____ **Date of Birth:** _____

Home address: _____

Telephone Numbers: _____ (H) _____(W) _____(C)
Email _____

College/University : _____
Graduation/Expected Graduation Date: _____
Cumulative GPA: _____
(Bring transcripts)

Current learning and/or psychiatric diagnoses _____
Who diagnosed_____
Known genetic disorders or medical diagnoses:_____

Are you taking any medications at this time? If yes, list all medications and current dosages and length of time your child has been on the medication.

Name of Current Medication(s)	Dosage	Since (date)

Are you employed? _____Yes _____No (if yes, specify how long job held and # hours/week)

What problems or questions have caused you to seek help at this time?

Family History

1. Are you adopted?
____ Yes
____ No

2. Please complete the following information regarding biological parents in the appropriate column:

	Mother	Father
Age		
Highest Level of Education Completed		
Degrees/Diplomas		
Current Occupation		
Describe any special education or tutoring received		
Describe grades repeated or subject areas that were difficult		
Any diagnosed learning difficulties? If so in what subjects?		
Any psychological or psychiatric problem for which treatment was received?		
Any Attention Deficit Disorder (with or without Hyperactivity?)		

3. **If any of the following parental relationships are relevant, please circle relevant relationship and complete:**

	Adoptive Mother/Stepmother	Adoptive Father/Stepfather
Age		
Highest Grade Completed		
Occupation		

4. **Siblings in the family (including step-siblings and half-siblings)**

Name	**Gender**	**Age**	**In home?**	**Social/Behavioral/Health problems? List**

5. **Biological extended family**

Do any extended family (maternal/paternal grandparents, uncles, aunts, cousins) suffer from any of the following: inattentiveness or hyperactivity; behavior problems; learning difficulties; epilepsy; seizures; migraines; alcoholism/drug abuse; psychological, emotional or personality difficulties; depression or bipolar disorder; schizophrenia; developmental disabilities; Autism or Aspergers disorder; Anxiety or "nervousness"; congenital abnormalities ; other neurological conditions etc.? If so, please list the relationship, the disorder and any treatment received:

Maternal (mother's side) **Paternal (father's side)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please provide any additional information about your extended family that might help me understand your needs (medical, behavioral, psychological, educational, and emotional):

_____

_____

_____

6. **Do you know if there were any complications during your mother's pregnancy with you or during your birth. Please use the lists below as a guide.**
   Length of pregnancy _____ weeks

   Any of the following complications during pregnancy

   _____Difficulty in Conception
   _____Abnormal Weight Gain
   _____Excessive Vomiting
   _____Excessive Swelling
   _____Vaginal Bleeding
   _____Anemia
   _____Other (e.g. Rh incompatibility)
   _____Toxemia
   _____Measles
   _____German Measles
   _____Emotional Problems
   _____Flu
   _____High Blood Pressure
   _____Maternal Injury
   _____Hospitalization during pregnancy (what month_____)
   _____X-Rays during pregnancy (what month? _____)
   _____Medication during pregnancy (what?_____)
   _____Alcohol during pregnancy (frequency_____)
   _____Cigarettes during pregnancy (frequency_____)
   _____Other drugs during pregnancy (Type and frequency_____)
   _____ Drugs while trying to conceive (mother)
   _____ Drugs while trying to conceive (father)

7. **Birth**:
   Born in a hospital? ____Yes _____No
   Length of Labor: _____ hours
   Birth Weight: _____lbs. _____ozs.
   Condition at birth _____
   Check the relevant birth details:

   ____ Vaginal delivery
   ____ Forceps used
   ____ Induced Labor
   ____ Caesarean Section
   ____ Breech Birth
   ____ Incubator needed
   ____ Delivery complications (describe _____)
   ____ Jaundiced (If yes, Bilirubin lights? _____Yes _____No)
   ____ Breathing problems right after birth (describe_____)
   ____ Supplemental oxygen (how long needed_____)
   ____ Birth defects (explain_____)
   ____ NICU stay (details_____)

8. **Did you have frequent ear infections as an infant/young child?** _____Yes _____No
   If yes, did you have ear tubes inserted surgically ?: _____Yes _____No

9. **Were your developmental milestones were on time (e.g. walking, first words etc.)**
   _____Yes (Details_____) _____No ____Don't know

10. Did you ever receive Occupational Therapy

_____Yes (Details_____) _____No ____Don't know

11. Did you ever receive Physical Therapy

_____Yes (Details_____) _____No ____Don't know

12. Did you ever receive speech and/or language therapy?

_____Yes (Details_____) _____No ____Don't know

13. Are you left or right handed? _____

14. Who is your primary Physician? (No information will be released or obtained without your written permission)

Name_____ Office Phone Number_____

15. Have you ever had a psychiatric or neurological examination?

_____Yes (Details_____) _____No

16. Are you currently under psychiatric or neurological care, please give the name, address and phone number of the treating physician. (No information will be released or obtained without your written permission) _____Yes _____No

Name_____ Office Phone Number_____

17. Do you wear a hearing aid? _____Yes _____No

18. Do you wear glasses/contact lenses? _____Yes _____No

19. What time do you go to bed?_____ **20. What time do your get up?** _____

21. Is your sleep consistent?

_____ Yes _____ No

22. Are you concerned that you don't get enough sleep and/or have poor sleep quality?

_____ Yes _____ No

23. Rate your alcohol use?

___Never _____ Occasionally (1x/week or less)____2-4x/week ____Daily

24. Rate your drug use?

___Never _____ Occasionally (1x/week or less)____2-4x/week ____Daily

25. List all drugs you have tried

26. Medical History: Please indicate whether you have had any of the following significant illnesses/conditions

Condition	Yes	No	Comments (include meds.)
Measles			
German Measles			
Mumps			
Chicken Pox			
Tuberculosis			
Rheumatic Fever			
Diphtheria			
Meningitis			
Encephalitis			
Whooping Cough			
Scarlet Fever			
Head Injury			
Coma or loss of consciousness			
Sustained high fever			
Any fever above 104 degrees			
Anemia			
Broken bones			
Asthma			
Sinus condition			
Surgery 1. 2. 3.			
Allergies to food			
Allergies to medicine			
Environmental allergies			
Respiratory Conditions			
Frequent Colds			
Chronic Cough			
Asthma			
Hay Fever			
Sinus Condition			
Cardiovascular Conditions			
Shortness of breath with exertion			
Dizziness with exertion			
Heart condition			
Heart Murmur			

27. Please indicate whether you have had any of the following significant illnesses/conditions

Gastrointestinal Conditions	**Yes**	**No**	**Comments (include meds.)**
Excessive Vomiting			
Frequent Diarrhea			
Constipation			
Stomach Pain			
Genitourinary Concerns			
Urination in pants/bed			
Pain while urination			
Excessive urination			
Strong odor to urine			
Musculoskeletal Concerns			
Muscle Pain			
Clumsy Walk			
Poor posture			
Other muscle problems			
Skin Concerns			
Frequent rashes			
Bruises easily			
Sores			
Severe Acne			
Eczema			
Neurological Concerns			
Seizures/convulsions			
Speech defects			
Accident prone			
Sucks thumb			
Grinds teeth			
Bites nails			
Picks skin			
Tics/Twitches			
Bangs head			
Rocks back and forth			
Unusual body movements			
Speech Concerns			
Stuttering			
Unclear speech			
Other speech problems			

28. Please also list any medication taken in the past for longer than 3 months duration.

Name of Previous Medication(s)	Dosage	From (date)	Until (date)

29. Describe your use of screens (TV; Gaming consoles; Computers)

____ Less than 1 hr/day
____ 1-2 hrs/day
____ 2-4 hrs/day
____ more than 4 hrs/day

30. Does you use social networking access (e.g. facebook)

_____ Yes _____ No

_____
_____
_____

31. Which of the following best describes your social interactions?

i. I am satisfied with my social life and peer interactions.
ii. I am dissatisfied with my social life and peer interactions

32. The following table is designed to assess your ability to relate to others.

	Yes	No
Do you have difficulty relating to others?		
Do you verbally argue a lot with others?		
Do you have difficulty making friends?		
Do you have difficulty maintaining friendships?		
Do you have at least one good friend?		
Are your invited to friend's houses?		
Do you like to host others at your house?		
Do you have a small group of good friends?		
Do you prefer to be alone?		
Do your have difficulty with the non-verbal rules of social interaction (e.g. turn taking, how close to stand to others)		

33. Add any comments about your social circumstances that are relevant:

34. Educational History. Please identify all schools you have attended giving dates of attendance in sequential order beginning with high school

Name of School/University	From (date)	To (date)

35. Have you ever been retained a grade in school? _____ Yes _____ No

36. Have you ever skipped a grade in school? _____ Yes _____ No

37. Have you ever had difficulty with reading? _____ Yes _____ No

38. Have you ever had difficulty with math? _____ Yes _____ No

39. Have you ever had difficulty with writing/spelling? _____ Yes _____ No

40. Have you ever had psycho-educational testing
_____ Yes (**If yes, bring copies of reports to your intake appointment**) _____ No

41. Have you ever had your any private tutoring
_____ Yes (If yes, give details_____) ____ No

42. Please bring standardized achievement tests taken at school if you have those records available (MAP/ERB/SAT/ACT etc.) and school reports (high school) and college transcripts if you are still in undergraduate education. If beyond undergraduate education, bring college transcripts if you have them.

43. Work History: Please indicate below all jobs you have held since age 16 (if in college) or from college graduation if past college age. List the job title and amount of time spent working in this position.

a. _____
b. _____
c. _____
d. _____
e. _____

44. Please circle the traits/characteristics below which apply to yourself:

Happy	Sad	Moody
Friendly	Quiet	Overactive
Independent	Dependant	Sensitive
Affectionate	Fearful	Overreacts when faced with a problem
Tantrums	Lethargic	Requires a lot of parental attention
Too responsible	Even tempered	Short attention span
Impulsive	Angry	Lacking in self control
Explosive	Volatile	Withholding of affection
Thoughtful	Dreamer	Difficulty calming down
Cooperative	Withdrawn	Easily over-stimulated

45. Other words you would use to describe yourself:

46. Please describe any major family stressors that may have impacted you in the past or that may impact you now:

47. Are there any particularly traumatic or troubling events which have happened in your life which I should know about in order to understand you better? (please give details, include incidents you feel were traumatic even though they might not have been for someone else)

48. Have you ever witnessed violence inside or outside of the home? Yes____ No____

49. Have you ever had psychological counseling or therapy?

____ Yes, If Yes, please give details below: ____ No

Therapist Name	**Address**	**Phone Number**	**Dates of treatment**

50. Please list the names, addresses, and telephone numbers of any other professionals consulted. (This does not give me permission to contact them, and they will only be contacted with your written consent.)

51. Is there any additional information or anything that you feel is pertinent to know that has not been covered in this questionnaire?

52. What changes do you hope will result from seeking comprehensive psychological assessment services?

53. Who referred you to Dr. Aviv's clinic?