JGHPSC Client Information Form for LD/ADHD Assessment

Please answer in the blank spaces provided or circle the appropriate answer.

General Information:

Date: ____

Name: ____

Social Security #: ____

Address: ____

Telephone (Home): ____ Best Times to Call (Home): ____

(Work): ____ (Work): ____

Date of Birth: ____ Age: ____

Marital Status:

____ Married ____ Cohabitating How Long? ____

____ Widowed Previous Marriages? ____

____ Single ____ Divorced How long since divorce? ____

List below the people now living with you:

Name	Relationship	Age	Occupation

Person to be contacted in case of emergency:

Name: ____

Address: ____

Telephone: ____

Relationship to you: ____

Race:

__ Caucasian __ African American __ Hispanic __ Asian __ Other:

Current annual family income (Circle range):

$35,000 or more
$30,000-34,999
$25,000-29,999
$20,000-24,999
$15,000-19,999
$10,000-14,999
$7,000-9,999

Number of dependents (not including yourself): ____

Childhood Information:

List below any people you lived with for a significant period of time during your childhood:

Name	Relationship to you

As far as you know were there any problems with your mother's pregnancy or delivery of you?
Yes No
If yes, specify:

As far as you know, did you walk, talk, and sit up on time? Yes No
If no, specify:

Did you parents complain that you were difficult to control as a child?
Yes No Not sure

Did you ever run away from home overnight? Yes No

If yes, How many times did you run away? (circle one)

a. Once b. Two to five times

c. Six to ten times d. More than ten times

II. What was the longest duration you ran away from home? (circle one)

a. One night b. Two to five nights

c. Six to ten night d. Longer than ten nights

Did you ever get in trouble for stealing or damaging property as a child or teenager? Yes No

If yes, specify: ____________________

Family Information

Father:
Living: Yes No
If yes: Age: ____ Occupation: ____
Current residence: ____
How often do you have contact? ____
If no: His age at death: ____ Your age at his death: ____
Cause of death: ____

Mother:
Living: Yes No
If yes: Age: ____ Occupation: ____
Current residence: ____ How often do you have contact? ____
If no: Her age at death: ____ Your age at her death: ____
Cause of death: ____

Brothers and Sisters:

Name	Age	Occupation	Residence (city)	How much contact?

Children:

Name	Age	Occupation	Residence (city)	How much contact?

Is there anyone in your family that has been in trouble with the law? Yes No
If yes, specify: ____

Are there any medical illnesses that run in your family? Yes No
If yes, specify: ____

Does anyone in your family have any of the following problems? (please check)

Problem	Family member who has it
___Anxiety	____________________
___Depression	____________________
___Alcohol abuse/dependence	____________________
____Drug abuse/dependence	____________________
____Psychiatric Illness	____________________
___Seizures	____________________
___Neurological Problems	____________________
___Tourette's syndrome	____________________
___Vocal tics	____________________
___Movement disorder	____________________
___Unusual movements	____________________
___ Heart problems	____________________
___ High blood pressure	____________________
___Attentional problems	____________________
___ADHD	____________________
___Learning disabilities	____________________

Educational Information:

Highest grade completed in school:

___Elementary (1-6) ___Junior High (7-9) ___Senior High (10-12)

___College Degree: ______

___Graduate/Professional/Technical School Degree: _____

Currently enrolled in school? __________

If so, where? ______________________________

Did you have any trouble starting school in kindergarten or first grade?

____

Did you ever repeat a grade? Yes No

If yes, which grades did you repeat? ___ ________________________

Were you ever in any special classes in school? Yes No

If yes, what kinds of special classes were you in?

____

How would you describe your grades in school?

Average ___ Better than average ___Worse than average

What was your best subject in school? ______________________________

What was your worst subject in school? ______________________________

Did your teachers think you did as well as you could? Yes No Not sure

Did you ever skip school? Yes No

If so, how often and during what grades? ___ ____ ____

Were you ever expelled or suspended from school? Yes No

Did you ever get in any physical fights at school? Yes No

If yes:

I. During which grades did you get into fights?

__ K-6th grade ___ 7th or 8th grade __ High school ___ Other

How many times did you get into fights? (circle one)

a. One time b. Two to five times

c. Six to ten times d. More than ten times

II. Did you sometimes start the fight? Yes No Not sure

IV: Did you ever use a weapon in a fight? Yes No

Legal Information:

Have you ever been arrested or in trouble with the law? Yes No

Do you have a driver's license? Yes No

If yes:

I. How many traffic tickets (not parking tickets) have you gotten? (circle one)

a. None b. One

c. Two to three d. Four to five

II. How many car accidents have you ever been in? (circle one)

a. None b. One c. Two

d. Three e. Four or more

If no: Why don't you have a driver's license?

Have you ever served in the military? Yes No

Employment Information:

Current and previous jobs:

Job title   Employer (company name and city)   Approximate dates

____

____

____

____

Personal Medical Information/History

Height: ______   Current Weight: _______

Medical conditions:

__ Asthma   __ Cancer   __Diabetes   __ Emphysema   __ Head injury

__ Hypertension   __ Hyperthyroidism   __ Heart attack   __ Pain   __ Sleep apnea

__ Seizures   __ Stroke   ___Heart Problems   ___Liver disease   __Glaucoma

___Chest pain/Shortness of breath   ___Encephalitis/Brain infection

__ Other ________________________________

Did you have any childhood illnesses? Yes No
If yes, specify: ________________________________

Have you ever had any seizures? Yes No
If yes, specify: ________________________________

Have you ever had an injury to your head? Yes No
If yes, specify: ________________________________

Have you ever lost consciousness? Yes No
If yes, specify: ________________________________

Have you ever had or do you now have any tics or unusual movements of your body? Yes No

Have you ever had or do you have any vocal tics, or do you make any unusual noises (Tourette's syndrome)? Yes No

Are you right-sided or left-sided?

Writing ____

Kicking ____

Throwing ____

Sighting/Pointing ____

Have you ever had any problems with your thyroid gland? Yes No
If yes, specify: ______________________________

Previous surgeries (with dates): ______________________________

____

Other Injuries/hospital admissions (with dates): ______________________________

____

Current medications & dosage:

____

____

Do you have any allergies to medications? Yes No
If yes, specify which medications: ______________________________
Do you have any other allergies? Yes No
If yes, specify: ______________________________

Sexually active? Yes No

Mental Health Information

Have you ever seen a counselor or psychiatrist before? Yes No
If yes, specify:

Have you ever been hospitalized for a psychological or psychiatric problem? Yes No
If yes, specify:

Have you ever had problems with depression? Yes No
If yes, specify:

Have you ever had problems with anxiety? Yes No
If yes, specify:

Substance Use Information

How much alcohol do you drink in a week? ______________________\

Do you ever drink more heavily? Yes No

If yes, how much?

Have you ever used drugs recreationally? Yes No

Do you use any drugs recreationally now? Yes No

If yes, specify: ________________________________

Drug	When Used	Frequency
Pot, marijuana, hashish, grass		
Amphetamines, stimulants, uppers, speed		
Barbiturates, sedatives, downers		
Sleeping pills, Seconal, Quaaludes		
Tranquilizers, Valium, Librium		
Cocaine, coke, crack		
Heroin		
Opiates other than heroin (iodine, Demerol, morphine Methadone, Darvon, opium)		
Psychedelics (LSD, mescaline, peyote DMT, PCP)		
Other		
Prescription drugs (not for the purpose they Were prescribed)		

If you have ever taken amphetamines, what was your response?______________

____

How much do you smoke? __________________________________

How much caffeine do you drink, including caffeinated tea and soda? ________

____