SUMMIT CENTER
Reach New Heights

# ADULT QUESTIONNAIRE

Dear Client,

Please fill out this form as best you can. Having all the facts will help us do the most thorough evaluation and be most helpful to you. If you can't remember something exactly, put an approximate answer with a question mark. Please feel free to use the backs of the pages for extended answers.

Date Completed:_____

Client's Name:_____Birthdate: _____

Gender:_____Age:_____ Ethnicity: _____

Home telephone:_____Work telephone: _____

Cell: _____

Email: _____

Home Address: _____

City:_____State:_____Zip Code: _____

Primary language:_____Other languages spoken:_____

Client's Handedness (Please circle) Left Right Ambidextrous

Emergency Contact and Phone Number:_____

Did you consult with anyone else while completing this form?:_____

How did you hear about Summit Center?:_____

Hair color:_____Eye color: _____

Date of last vision test & results: _____

Who conducted the evaluation (please circle and name
Name: _____

Do you wear glasses (If so, since what age?): _____
Date of last hearing test & results: _____
Who conducted the evaluation? _____
Do you wear hearing aids (If so, since what age?): _____

What specific questions do you hope to have answered by this evaluation/consultation and/or treatment (e.g., learning issues, giftedness, social, and/or emotional issues)? _____

_____

_____

Describe any recent medical, academic, or other events that led to this assessment.

_____

_____

What are your concerns? What do you think may be causing the difficulties you are concerned about?

_____

_____

What interventions have you tried in the past to help with these areas of difficulty? (e.g., tutoring, counseling, speech therapy, occupational therapy, behavior management programs, etc.)

_____

_____

What do you consider to be your greatest:

A. Strengths: _____

B. Challenges:_____

Have you already been given any diagnoses? ☐ Yes ☐ No
If yes, what are they? _____

By whom, and when? _____

Do your sibling(s) have a diagnosis? ☐ Yes ☐ No
If yes, what is it/are they? _____

Have you already had testing/evaluations/504 Plan/IEP? If yes, what were the results and conclusions? (Please include copies of relevant reports and IEPs.) _____

_____

## BACKGROUND HISTORICAL INFORMATION

### Pregnancy

How was your mother's health during the pregnancy? _____

Were there any prenatal or perinatal complications, or complications in childbirth? _____

- ☐ Mother smoked while pregnant (if yes,_____packs/day)
- ☐ Mother drank alcohol while pregnant (if yes, amount_____)
- ☐ Mother took drugs while pregnant (e.g. cocaine, speed, heroin, marijuana, etc.)
- ☐ Mother took medications (prescribed/ over the counter) while pregnant? If yes, what? _____

  If yes to medications, what months were these taken? _____
- ☐ RH incompatibility between mother and baby
- ☐ Mother had an accident/ injury
- ☐ Mother was anemic
- ☐ Mother had diabetes
- ☐ Mother had high blood pressure
- ☐ Mother had illnesses/ infections
- ☐ Mother had preeclampsia, eclampsia, or toxemia
- ☐ Mother had spotting or bleeding
- ☐ Mother had surgery
- ☐ Mother had vomiting (severe or frequent)
- ☐ Mother experienced severe emotional stress and/or psychological problems during pregnancy
- ☐ Episodes of false labor
- ☐ Baby had unusual level of activity within the womb: ☐ more ☐ less active than other pregnancies
- ☐ How often did mother see her doctor during the pregnancy (circle one)?

  ☐ Regularly (as scheduled by the doctor) ☐ Rarely ☐ Not at all
- ☐ Other _____

**Childbirth**

Where were you born (hospital/city)? _____

If known, length of mother's pregnancy (in weeks)_____
Length of labor (hours)_____Was labor induced? ☐ Yes ☐ No

Birth was: ☐ Normal/vaginal ☐ Breech ☐ Cesarean ☐ Twins/multiple births ☐ Other _____

How was labor for the mother (circle one)? Easy Moderately difficult Very difficult

If known, what were your APGAR scores? _____

Which of the following were used to assist in delivery?

☐ Epidural ☐ Other anesthesia ☐ Forceps ☐ Vacuum

If known, did you need any medical help starting to breathe/ fail to cry/ or appear inactive at birth? _

Describe any other complications in the birth _____

Birth weight:_____lbs._____oz. Length:_____At birth, were you in the NICU? ☐ Yes ☐ No

If so, for how long? _____

If known, did you have any difficulty with any of the following during the first month of life?

☐ Evaluation in the intensive care nursery?

☐ Jaundice - Did the baby receive bilirubin lights?

☐ Cyanosis ("blue baby")

☐ Excessive crying

☐ Seizures

☐ Failure to thrive

☐ Feeding problems

☐ Did you receive any medications as a baby? If so, which ones? _____

☐ Did your mother have any other postpartum complications? _____

☐ As a baby, did you have to stay in the hospital for an extended time? ☐ Yes ☐ No

☐ Other _____

## MEDICAL HISTORY

**Primary Care Physician's name and phone number:**

_____

When was your last visit with the physician? _____

Please check all of the following that you have experienced and explain in the open space following:

- ☐ Hospitalizations _____
- ☐ Surgery _____
- ☐ Trauma (lacerations, fractures, serious accidents, injuries, etc.) _____
- ☐ Head injury _____
- ☐ Loss of Consciousness _____
- ☐ Seizures/convulsions/fits _____
- ☐ Meningitis _____
- ☐ Serious illnesses/infections/high fevers _____
- ☐ Asthma _____
- ☐ Allergies (any food/medication allergies) _____
- ☐ Ear infections: How many/ when? What was treatment? _____
- ☐ Hearing problems _____
- ☐ Vision problems _____
- ☐ Sleep problems (including nightmares, sleepwalking, bedwetting, etc.) _____
- ☐ Other problems or medical diagnoses: _____
- ☐ Medications (Please list all current medications. Specify type, dosage and for treatment of what condition)

_____

Do you have any concerns about your eating habits, diet, nutrition, or growth? ☐yes ☐no

If yes please describe: _____

Have you ever been in counseling or therapy? Please describe any previous counseling—reasons for treatment, length of treatment, therapist name, type of treatment (e.g., family, individual, group therapy).

_____

_____

_____

## DEVELOPMENTAL HISTORY

Did you achieve motor milestones on time? ☐Yes ☐ No

At what age did you start crawling?_____months. First walk?_____months

Do you have any concerns about the your strength and coordination? ☐Yes ☐ No

If yes, please describe. _____ Did you achieve language milestones on time? ☐Yes ☐No

At what age did the did say your first words?_____months

At what age did the you say your first sentence_____months

Do you speak clearly? ☐Yes ☐ No If no, what sounds are hard to say? _____

Do you have trouble picking up on nonverbal cues such as gestures or humor?☐Yes☐No

Please describe any other concerns you have about your language development. _____

---

As a child, did you have a history of any of these issues?

☐ Head banging _____

☐Stuttering _____

☐Breath holding _____

☐Toileting problems _____

☐Temper tantrums _____

☐Nail biting _____

☐Excessive jealousy _____

☐Hitting _____

☐Frequent crying _____

☐Irritability _____

☐Frequent thumb sucking _____

☐Hurting self _____

☐Bed wetting _____

☐Excessive fears _____

☐Excessive fantasizing _____

☐Intentionally hurting others _____

☐Problems going to school/work_____

☐Problems making friends _____

☐Unusual behaviors (e.g., rocking, flapping, picking at self, etc.) _____

☐Changes in weight or appetite _____

☐Changes in mood _____

☐Changes in energy level _____

☐Do you get regular exercise? _____

If so, how often? What type? _____

☐Sleep related issues:

How many hours per night do you sleep? _____

Do you have any of the following (please circle). If so, please explain.

☐Insomnia ☐Nightmares ☐Frequent waking during the night

☐Night terrors ☐Sleepwalk

## FAMILY/SOCIAL HISTORY

Were you adopted? ☐Yes ☐No If yes, from where? _____ Foster child? _____

Your parents ☐married ☐ divorced since _____ ☐ separated since _____
☐ single ☐ other _____

Information regarding biological parents:

Name/ Age/ Occupation Parent 1: _____

Name/ Age/ Occupation Parent 2: _____

Please indicate any health problems of the parents. If deceased, please indicate age/cause of death.

_____

Please check all of the following which, if any, your immediate biological relatives (e.g., father/mother, grandparents, brother/sister, aunt/uncle, cousin) may have had, and explain as necessary at the bottom:

- ☐ Inherited/genetic condition
- ☐ Birth defects
- ☐ Cerebral palsy/ neuromuscular disorders
- ☐ Slow or delayed development
- ☐ Learning disabilities/ dyslexia
- ☐ Hyperactivity/attention deficit disorder (ADD, ADHD)
- ☐ Hearing/visual problems
- ☐ Thyroid or other hormone disorder
- ☐ Cancer
- ☐ Alcoholism or drug abuse
- ☐ Emotional problems/nervous breakdown
- ☐ Schizophrenia
- ☐ Manic Depression/Bipolar Illness
- ☐ Depression
- ☐ Anxiety
- ☐ Autism/
- ☐ Asperger's
- ☐ Gifted

Other _____

Any other relevant information about the family (i.e. information about divorce, remarriage, parental death, death of other important family figures, etc.) or significant life stressors (i.e. moving, change of school, etc.) that you would like me to know about? _____

_____

_____

Briefly describe your socialization history.

How well do you relate to other people?

_____

_____

Has this pattern changed over time? _____

_____

Do you prefer: Group activities Individual activities Either

_____

**EDUCATIONAL HISTORY**

Describe your school history. What schools have you attended?

| **School** | **For Which Grades?** | **Type of School i.e Public/Private** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Did you have any early educational difficulty (like trouble learning to read)?

_____

Did you receive any intervention services or school accommodations? If so, which ones? When?

_____

Have you repeated or skipped any grades? If so, which ones?

_____

In what academic areas have you done well or done poorly?

_____

Do you or have you received any of the following services? (Please Circle)

| | | | |
|---|---|---|---|
| Occupational Therapy | Physical Therapy | Pull-Out Tutoring | Placement in Special Classroom |
| Resources Room Access | Placement in a Special School | Gifted Program | Education Therapy |
| Speech Therapy | Counseling/Therapy | Vision Therapy | Other _____ |

Do you or did you enjoy going to school? If not, why?

Do you or did you get along with your teachers and peers? _____

## VOCATIONAL HISTORY

Describe your relevant vocational history.

| **Place of Employment** | **Length of Employment** | **Challenges and Strengths** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## OTHER

What are your favorite activities? _____

What are your least favorite activities? _____

Is there anything else you wish to add that has not been covered by this questionnaire?