

HERMAN & ASSOCIATES

A PSYCHOLOGICAL CORPORATION

Adult Extended Intake Information Form

General Information

Client

- Name: _____ Today's Date: _____ Age: _____ Gender: _____
- Date of birth: _____ Place of birth: _____ SSN: _____
- Home Address: _____ City: _____
- Zip Code: _____ Home phone: () _____ cell: () _____
- e-mail address: _____ Referred by: _____
- Check the box for the racial or ethnic group with which you identify:
 Caucasian African American Hispanic Asian/Asian American
 Native American Other: _____
- What culture do you identify with? _____

Emergency

- In case of emergency, please call: _____ Telephone: () _____
- I have received and agree with the informed consent: No Yes

Consultant Information

• Physician

Name: _____ Address: _____
City: _____ Zip: _____ Phone: () _____

• Other Professionals

Type of Service: _____
Name: _____ Address: _____
City: _____ Zip: _____ Phone: () _____
Type of Service: _____
Name: _____ Address: _____
City: _____ Zip: _____ Phone: () _____

Current Living Situation

Living Arrangement

- With whom do you live?
 Parents Present family (spouse/children) With partner Alone Roommates
 Other: _____
- Problems with current living arrangement: Yes No If yes, specify: _____

Family of Descent

- Marital status: Single Engaged Married Separated Divorced Widowed
If married:
Spouse Name: _____ Age: _____
Name and ages of children:
1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____
- Problems with family of descent: Yes No If yes, specify: _____

Occupation

- Title: _____
- Business Name: _____
- Business Address: _____ City: _____
- Zip Code: _____ Work phone: () _____
- Duties: _____
- Annual Family Income: \$ _____
- Problems with occupational life: Yes No If yes, specify: _____

→ Please attach a resume, or CV, with this intake form.

Family Background

Parents

- Mother's Name: _____
- Mother's Education Level: _____ Occupation: _____
- Give a description of your mother's personality:

- Father's Name: _____
- Father's Education Level: _____ Occupation: _____
- Give a description of your father's personality: _____

- If parents are separated or divorced: Date: _____ Your age: _____
Your reaction: _____
- Is a parent deceased? No Yes If yes, please specify: _____
- Are you adopted? No Yes Guardianship as a child? No Yes
- Are you satisfied with your family relationships? No Yes
- Are there any family problems that you feel might be contributing to your difficulties?
 No Yes If yes, please describe: _____

Siblings

- Please list all siblings (including step-siblings), current ages, gender, and a brief description of your relationship with them.
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____

Family Relationships

- Please describe your relationship with your:
Mother: _____
Father: _____

Siblings: _____

Others: _____

- Please describe the parenting styles of each parent:

- How did your parents handle discipline issues? _____

- What were the most difficult behaviors for your parents to handle? _____

- How much supervision did you need compared to peers? More Same Less

Developmental History

Pregnancy

- Mother's overall health during pregnancy: _____

- Was mother exposed to any infectious diseases (e.g., rubella, syphilis, AIDS, toxoplasmosis) during the pregnancy? No Yes

- Medications used by mother during pregnancy:

None

Prescription medications,

Name: _____

Non-prescription medications,

Name: _____

Caffeine Tobacco Alcohol Other: _____

- Mother's diet during pregnancy: Good Average Poor

- Did mother take daily vitamins during her pregnancy? No Yes

- Medications used by father 6 months prior to pregnancy:

None

Prescription medications,

Name: _____

Non-prescription medications,

Name: _____

Caffeine Tobacco Alcohol Other: _____

- Father's diet prior to pregnancy: Good Average Poor

- Was the father's exposed to high amounts of tetragons such as radiation, lead, or pesticides prior to pregnancy? No Yes

Birth

- Mother's age at delivery: _____ Any labor or birth complications: _____

APGAR Scores (if known) : 1 min. _____ 5 mins. _____ 10 mins. _____

Premature, weeks early: _____ On Time Late, weeks late: _____

Evidence of fetal distress: _____

- Birth weight: _____
- Were you taken away following delivery? No Yes
- Were you allowed to nurse following delivery? No Yes
- Father's age at delivery: _____

Sensory Functioning

- Are you aware of any problems you have processing sensory information (e.g., visual, auditory, touch, taste, smell)? If yes, please explain: _____

- Do you have synesthesia? No Yes. Synesthesia is the involuntary stimulation of one sensory modality reliably causes a perception in one or more different senses? For example, letter/numbers may have colors (e.g., the letter "A" may be red), a person might describe the color, shape, and flavor of someone's voice, music has a shape to it, or a scent is associated with a color.

- Are you "hypersensitive" to, or does it cause you undue stress/anxiety, when you encounter:
 - light touch sudden movement high frequency noises
 - excessive noise excess of visual stimuli certain smells
 - certain foods/tastes

Early Development

- Did you "nestle"? No Yes
- Did you prefer separate space to being held? No Yes
- Did you prefer to be tightly wrapped or "swaddled"? No Yes
- Were your cries soothed when: ...fed? No Yes ...held? No Yes

...changed? No Yes...bathed? No Yes ...rocked? No Yes

- Were you breast fed? No Yes
- Were there *feeding problems*? If yes, please describe: _____
- Did you sleep in a separate crib? No Yes
- Was the crib in the same room with your mother? No Yes
- What was your *general temperament* during the early years?
 Easy, adaptable Withdrawn, slow to adapt Difficult, intense reactions

Colicky

- Did you attach to the primary caretaker? No Yes
- Who was the primary caretaker? _____
- Would you consider the *early attachment* between you and your mother:
 Strong Moderate Weak
- How would you describe your early *sleeping patterns*?
 Regular and predictable Irregular and unpredictable
 Required very little sleep Required much sleep
- How would you describe your early *feeding patterns*?
 Regular and predictable Irregular and unpredictable
 Required little food Required much food
- What was your early *general activity level*?
 Hyperactive Active Average Low energy Lethargic
- In general, were you: Easy to care for Difficult to care for
- How did you respond to *changes in routine* or to *transitions*?
 Easy, adaptable Withdrawn, slow to adapt Difficult Crying/Screaming
- Did *toilet training* present any difficulties? No Yes If yes, please describe:

-
- Were you exposed to *physical abuse*? No Yes
 - Were you exposed to *emotional abuse*? No Yes
 - Were you exposed to *sexual abuse*? No Yes
 - Were you exposed to any traumatic events? No Yes, what: _____

-
- Please describe any other *significant events* during your early years (e.g., postpartum depression, illness, trauma, moves, marital difficulties) and their impact on this student:

Language Development

- During the first year of life, other than crying, would you say that you were a:
 Silent or very quiet baby Very noisy baby Verbally interactive baby
- How was your language development? Consistent With significant breaks

Medical History

- Date of last physical: _____
- Please describe your current health: _____

- Do you have any health problems that need to be addressed? _____

- Hearing: Normal Below average Wear aid Date of last check: _____
- Vision: Normal Below average Wear glasses Date of last check: _____
- Do you have a regular sleep schedule (e.g., pretty much 11pm to 7am nightly)? No Yes
- Do you have any problems falling or staying asleep? If yes, explain: _____

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This information will remain strictly confidential, but it is very important for me to know before you begin so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

Current	Past	Type	Frequency/Comments
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

- Are you attracted to stimulants (e.g., caffeine, cocaine)? No Yes
- How many cups of coffee, tea, caffeinated sodas do you drink a day? _____

- Do you have frequent physical complaints such as stomachaches or headaches that may be related to stress or tension? No Yes
- Do you smoke? No Yes, frequency: _____
- Do you drink alcohol? No Yes, frequency: _____
- What happens to you when you consume alcohol? _____

- Have you ever suffered from any of the following? (*check all that apply*)

Condition:	When?	Comments:
<input type="checkbox"/> Accidents		
<input type="checkbox"/> Allergies		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Ear infections		
<input type="checkbox"/> Head Injuries		
<input type="checkbox"/> Hospitalizations		
<input type="checkbox"/> Neurological sx's		
<input type="checkbox"/> Other Injuries		
<input type="checkbox"/> Seizures		
<input type="checkbox"/> Thyroid Problems		
<input type="checkbox"/> Tics		
<input type="checkbox"/> Other		

Eating Checklist

- Do you have a regular eating schedule (e.g., pretty much 3 balanced meals per day)?
 No Yes
- Describe your diet and any problems with eating _____

- Do you have any problems with eating? If yes, explain: _____

Yes	No	Question
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel society pressures you to be thin?
<input type="checkbox"/>	<input type="checkbox"/>	Do you believe you're preoccupied with food?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel guilty about eating?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel you need to be superior and perfect when it comes to academics, athletics or weight control?

<input type="checkbox"/>	<input type="checkbox"/>	Do you feel that your weight is one of the few aspects of your life you can control?
<input type="checkbox"/>	<input type="checkbox"/>	Do you diet excessively and/or abuse laxatives, diet pills or diuretics?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel isolated from your family?
<input type="checkbox"/>	<input type="checkbox"/>	Do you ever consume large amounts of food in a frenzy of hunger?
<input type="checkbox"/>	<input type="checkbox"/>	Do you induce vomiting after eating, particularly after a binge?
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise excessively?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel fat even though others tell you that you are thin?
<input type="checkbox"/>	<input type="checkbox"/>	Does your weight fluctuate dramatically?

Mental Health History

- Please list any current psychological symptoms or emotional difficulties: _____

- Please list any past psychological complaints: _____

- Have you ever been hospitalized for a mental health reason? No Yes
- Have you ever contemplated suicide? No Yes, when was the last time: _____
- Please list any previous outpatient mental health treatment/therapy experience: _____

Attentional Checklist *(Please check all statements that apply to you)*

- Do you consider yourself a video game player? No Yes, hours per day: _____
- What level video game player? Beginner Intermediate Advanced

Inattention

As a child	Now	Behavior
<input type="checkbox"/>	<input type="checkbox"/>	I often fail to give close attention to details and make careless mistakes.
<input type="checkbox"/>	<input type="checkbox"/>	I often have difficulty sustaining attention in tasks.
<input type="checkbox"/>	<input type="checkbox"/>	I often do not seem to listen when spoken to directly.
<input type="checkbox"/>	<input type="checkbox"/>	I often do not follow through on instructions and fail to finish tasks.

<input type="checkbox"/>	<input type="checkbox"/>	I often jump from one task to another.
<input type="checkbox"/>	<input type="checkbox"/>	I have difficulty getting organized.
<input type="checkbox"/>	<input type="checkbox"/>	I avoid and dislike tasks that require sustained mental effort.
<input type="checkbox"/>	<input type="checkbox"/>	I often lose things necessary for tasks or activities.
<input type="checkbox"/>	<input type="checkbox"/>	I am often distracted by noises outside (e.g., birds, voices next door, cars).
<input type="checkbox"/>	<input type="checkbox"/>	I am often forgetful in daily activities.
<input type="checkbox"/>	<input type="checkbox"/>	I have a tendency to tune out or drift away in conversations.
<input type="checkbox"/>	<input type="checkbox"/>	I find myself needing to reread a paragraph or page due to daydreaming.
<input type="checkbox"/>	<input type="checkbox"/>	I find it's important to "multitask" to keep focused on certain tasks (rapid shifting of attention from one task to another; doing several things at once).
<input type="checkbox"/>	<input type="checkbox"/>	I space out frequently.

Hyperactivity

As a child	Now	Behavior
<input type="checkbox"/>	<input type="checkbox"/>	I exhibit restlessness (fidget, squirm, shake leg, tap feet, pace, doodle).
<input type="checkbox"/>	<input type="checkbox"/>	Compared to peers, I have trouble sitting still.
<input type="checkbox"/>	<input type="checkbox"/>	I must be doing something nearly all the time.
<input type="checkbox"/>	<input type="checkbox"/>	I am often "on the go" or act as if "driven by a motor."
<input type="checkbox"/>	<input type="checkbox"/>	I talk excessively.
<input type="checkbox"/>	<input type="checkbox"/>	I take on projects simultaneously, but have trouble finishing them on time.
<input type="checkbox"/>	<input type="checkbox"/>	I am frequently in search of high stimulation.
<input type="checkbox"/>	<input type="checkbox"/>	I generally have a hard time relaxing.
<input type="checkbox"/>	<input type="checkbox"/>	I am generally impatient.
<input type="checkbox"/>	<input type="checkbox"/>	I smoke cigarettes.
<input type="checkbox"/>	<input type="checkbox"/>	I drink alcohol too much.
<input type="checkbox"/>	<input type="checkbox"/>	I change the radio station or TV channels frequently.
<input type="checkbox"/>	<input type="checkbox"/>	I was hyperactive as a child.
<input type="checkbox"/>	<input type="checkbox"/>	I would describe myself as hypersexual.

Impulsivity

As a child	Now	Behavior
<input type="checkbox"/>	<input type="checkbox"/>	I have a tendency to say what comes to mind without necessarily considering the timing or appropriateness of the remark.

<input type="checkbox"/>	<input type="checkbox"/>	I have trouble waiting my turn.
<input type="checkbox"/>	<input type="checkbox"/>	I tend to interrupt others.
<input type="checkbox"/>	<input type="checkbox"/>	I have trouble going through established channels in getting things done.
<input type="checkbox"/>	<input type="checkbox"/>	I am frequently impatient and have low frustration tolerance.
<input type="checkbox"/>	<input type="checkbox"/>	I spend money impulsively.
<input type="checkbox"/>	<input type="checkbox"/>	I am “hot-tempered.”
<input type="checkbox"/>	<input type="checkbox"/>	I am intolerant of boredom.
<input type="checkbox"/>	<input type="checkbox"/>	I have a tendency toward addictive behavior.
<input type="checkbox"/>	<input type="checkbox"/>	I have a hard time reading directions first.
<input type="checkbox"/>	<input type="checkbox"/>	I love to gamble.
<input type="checkbox"/>	<input type="checkbox"/>	I feel like exploding inside when someone has trouble getting to the point.
<input type="checkbox"/>	<input type="checkbox"/>	I often find myself involved in a situation without having planned it out.
<input type="checkbox"/>	<input type="checkbox"/>	I am accident-prone.
<input type="checkbox"/>	<input type="checkbox"/>	I have trouble keeping secrets.

Other

As a child	Now	Behavior
<input type="checkbox"/>	<input type="checkbox"/>	I have mood swings or mood lability.
<input type="checkbox"/>	<input type="checkbox"/>	I have chronic problems with self-esteem.
<input type="checkbox"/>	<input type="checkbox"/>	I have a history of underachievement.
<input type="checkbox"/>	<input type="checkbox"/>	I have trouble getting started on things.
<input type="checkbox"/>	<input type="checkbox"/>	I have the ability to “hyperfocus” on some projects or games.
<input type="checkbox"/>	<input type="checkbox"/>	I often procrastinate.
<input type="checkbox"/>	<input type="checkbox"/>	I have difficulty making myself understood to others.
<input type="checkbox"/>	<input type="checkbox"/>	I have tried cocaine and it slowed me down, rather than made me high.
<input type="checkbox"/>	<input type="checkbox"/>	I am unable to estimate time and space well.
<input type="checkbox"/>	<input type="checkbox"/>	I am drawn to situations of high intensity.
<input type="checkbox"/>	<input type="checkbox"/>	I have trouble with time-management.
<input type="checkbox"/>	<input type="checkbox"/>	I have trouble organizing (keeping an updated calendar or checkbook).
<input type="checkbox"/>	<input type="checkbox"/>	I work best in short spurts followed by a break.

Prior therapist information

Name: _____ Address: _____

City: _____ Zip: _____ Phone: () _____

- May we contact your previous therapist? Yes No, please explain: _____

- Please list any previous diagnoses: _____

- Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.

Family Mental Health History

- Has anyone in your *immediate or extended biological family* ever suffered from:

Condition	Who?	Comments
<input type="checkbox"/> Abuse Issues		
<input type="checkbox"/> ADHD/ADD		
<input type="checkbox"/> Alcoholism		
<input type="checkbox"/> Anxiety		
<input type="checkbox"/> Asperger's/Autism		
<input type="checkbox"/> Bipolar Disorder		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Epilepsy/Seizures		
<input type="checkbox"/> Hyper/Hypothyroidism		
<input type="checkbox"/> Learning Disability		
<input type="checkbox"/> Psychosis		
<input type="checkbox"/> Substance Abuse		
<input type="checkbox"/> Suicidal Behavior		
<input type="checkbox"/> Other		

Everyone has something they worry about. Please describe five things that worry you:

1. _____

2. _____

3. _____

4. _____

5. _____

School History

Early Education

- Were you read to nightly as a child? No Yes
- Were you able to listen and attend to stories? No Yes
- Did you attend preschool? No Yes Type: _____
- Did you attend kindergarten? No Yes Name: _____

Preschool Behavior

<input type="checkbox"/>	Trouble learning alphabet, days of the week, colors, shapes, numbers
<input type="checkbox"/>	Trouble following directions

Elementary School: _____

- Type of school: Public Private
 Regular education Special education Gifted program
- Type of program: Regular classroom Regular classroom with resource room
 Special day class (SDC) SDC with mainstreaming

Elementary School Learning Issues

<input type="checkbox"/>	Slow to learn the connections between letters and sounds
<input type="checkbox"/>	Trouble learning to blend sounds to make words
<input type="checkbox"/>	Made consistent reading and spelling errors
<input type="checkbox"/>	Problems remembering sequences
<input type="checkbox"/>	Trouble learning to tell time
<input type="checkbox"/>	Slow to learn new skills
<input type="checkbox"/>	Difficulty planning
<input type="checkbox"/>	Slow to learn prefixes, suffixes, root words, and other reading strategies
<input type="checkbox"/>	Avoided reading out loud
<input type="checkbox"/>	Difficulty with word problems in math
<input type="checkbox"/>	Avoided reading and writing tasks
<input type="checkbox"/>	Worked slowly
<input type="checkbox"/>	Difficulty understanding and/or generalizing concepts
<input type="checkbox"/>	Frequently misread directions/information
<input type="checkbox"/>	Confused the order of letters in words
<input type="checkbox"/>	Didn't recognize words previously learned

<input type="checkbox"/>	Didn't recognize the correct spelling of words
Elementary School Attention Issues	
<input type="checkbox"/>	Trouble paying attention in class, often daydreaming
<input type="checkbox"/>	Trouble sitting in chair to complete assignments
<input type="checkbox"/>	Trouble with impulsive behaviors

Middle School: _____

- Type of school: Public Private
 Regular education Special education Gifted program
- Type of program: Regular classroom Regular classroom with resource room
 Special day class (SDC) SDC with mainstreaming
- Please describe any problems you had in middle school: _____

High School: _____

- Type of school: Public Private
 Regular education Special education Gifted program
- Type of program: Regular classroom Regular classroom with resource room
 Special day class (SDC) SDC with mainstreaming
- Please describe any problems you had in high school: _____

• High School GPA: _____ SAT Verbal: _____ SAT Math: _____

Undergraduate College(s): _____

- Major(s): _____, Degree(s): _____ GPA: _____
- Please describe any problems you had in college: _____

Graduate School(s): _____

- Major(s): _____, Degree(s): _____ GPA: _____
- Please describe any problems you had in graduate school: _____

School Performance

Please check the appropriate box rating your basic academic skills.

Superior	Above Average	Average	Below Average	Very Poor	Typical Grade
----------	------------------	---------	------------------	--------------	------------------

Reading						
Language Arts						
Writing						
Math						
Science						
Social Science						

- Did you miss school regularly? No Yes
If yes, please explain: _____
- Do you have a history of school conduct problems? No Mild Moderate Severe
- Have you ever been: Expelled Suspended In Saturday School
- Were you retained? No Yes If yes, what grade? _____
- Do you think you've had a strong education to date? No Yes
- List any clubs, sports, or school activities in which you participated: _____

Special Services (Please check all special services you received)

Service		Service	
Speech/Language	<input type="checkbox"/>	Adaptive P.E.	<input type="checkbox"/>
Counseling	<input type="checkbox"/>	Educational therapy	<input type="checkbox"/>
Peer tutoring	<input type="checkbox"/>	Teacher help	<input type="checkbox"/>

- When were your academic problems first noticed? Who noticed them? What happened?

- Did you have an *Individual Education Plan* (IEP) written at school? No Yes
- *Special accommodations* received at school: _____
- Do you demonstrate *visual perceptual* difficulties (e.g., letter reversals; confusion between similar letters such as b/d or p/q, words, or numbers; problems copying from the board; difficulty lining up math problems) No Yes
- Have you demonstrated *auditory processing* difficulties (e.g., inconsistent following long oral directions; confusing similar sounding words such as mail and nail) No Yes
- Have you been aware of any *attentional or behavioral* problems? No Yes
- Favorite subjects: _____ Least favorite subjects: _____

Personality and Social Relationships

Personality (please use back of page as needed)

- Please describe your personality and general self-esteem: _____

- What are your favorite activities/interests? _____

Peer Relationships

- Number of close friends? None 1 2-5 6 +
- Are you satisfied with your friendships? No Yes
- My friendships are: Very close Somewhat close Lacking in closeness
- Please describe your friendships: _____

- Please describe any difficulties you may have with peer interactions: _____

Dating History

- Number of previous exclusive dating relationships: _____
- Age at first exclusive relationship: _____
- How do your relationships typically end? _____

- What are your relative strengths in these relationships? _____

- What are your relative weaknesses in these relationships? _____

- Are you satisfied with your dating experiences? No Yes
- Do you have any concerns about your sexual development or history? No Yes
If yes, explain: _____

- Did you have trouble paying attention while completing this form? No Yes

Please use the rest/back of this page to include any additional information you think I should know.