

Client Name: _____



Centers For Motivation, Inc.
Psychological Testing Services

INTAKE QUESTIONNAIRE

Client Information (Child or Student)

Client's Name _____	Date _____
Client's DOB _____	Father's Name _____
Gender _____	Mother's Name _____
Address _____	Handedness <input type="checkbox"/> Right
City _____	<input type="checkbox"/> Left
State _____	<input type="checkbox"/> Ambidextrous
Zip _____	
Phone _____	
E-mail _____	

School Contact Information

School Name _____	Grade _____
School Address _____	Contact Person _____
Phone _____	Position _____

What presenting problems or questions have led you to seek psychological testing?

Does the client suffer from any of the following symptoms? (check all that apply)

Depression

<input type="checkbox"/> chronic sadness	<input type="checkbox"/> low frustration tolerance
<input type="checkbox"/> crying episodes	<input type="checkbox"/> irritability
<input type="checkbox"/> hopelessness	<input type="checkbox"/> difficulty falling asleep
<input type="checkbox"/> difficulty concentrating	<input type="checkbox"/> difficulty staying asleep
<input type="checkbox"/> rapid weight loss	<input type="checkbox"/> early morning awakening
<input type="checkbox"/> rapid weight gain	<input type="checkbox"/> memory problems
<input type="checkbox"/> loss of appetite	<input type="checkbox"/> suicidal thoughts
<input type="checkbox"/> overeating	<input type="checkbox"/> suicide attempt
<input type="checkbox"/> nausea/vomiting	<input type="checkbox"/> withdrawal from others
<input type="checkbox"/> difficulty making decisions	<input type="checkbox"/> difficulty functioning at school
<input type="checkbox"/> recurring thoughts of death/dying	<input type="checkbox"/> difficulty functioning socially
<input type="checkbox"/> depressed mood	<input type="checkbox"/> low energy/fatigue
<input type="checkbox"/> decreased energy	<input type="checkbox"/> reduced interest/pleasure
<input type="checkbox"/> grief	<input type="checkbox"/> worthlessness
<input type="checkbox"/> guilt	

Client Name:

Anxiety

- | | |
|--|--|
| <input type="checkbox"/> agitation | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> restlessness | <input type="checkbox"/> fear of leaving home |
| <input type="checkbox"/> excessive worry | <input type="checkbox"/> avoidance of public places |
| <input type="checkbox"/> fearfulness | <input type="checkbox"/> avoidance of social situations |
| <input type="checkbox"/> trembling/shaking | <input type="checkbox"/> pounding heart/palpitations/shortness of breath |
| <input type="checkbox"/> fear of loss of control | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> fear of dying | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> difficulty relaxing | |

Stress/Trauma

- | | |
|---|---|
| <input type="checkbox"/> feeling detached from others/life | <input type="checkbox"/> flashbacks/re-living bad experiences |
| <input type="checkbox"/> intrusive thoughts of bad memories | <input type="checkbox"/> easily startled/upset |
| <input type="checkbox"/> nightmares | |

Eating Problems

- | | |
|--|---|
| <input type="checkbox"/> excessive eating | <input type="checkbox"/> obesity |
| <input type="checkbox"/> underweight | <input type="checkbox"/> self-induced vomiting |
| <input type="checkbox"/> abuse of laxatives | <input type="checkbox"/> obsessing about food, diet, exercise |
| <input type="checkbox"/> eating problems interfering with health | <input type="checkbox"/> exhaustion |

Thought Problems

- | | |
|---|--|
| <input type="checkbox"/> hearing voices others do not hear | <input type="checkbox"/> seeing things others do not see |
| <input type="checkbox"/> fearful others are talking about you | <input type="checkbox"/> fearful someone is plotting against you |
| <input type="checkbox"/> paranoia | <input type="checkbox"/> unaware of surroundings |
| <input type="checkbox"/> fixed false beliefs | <input type="checkbox"/> disrupted thoughts |
| <input type="checkbox"/> hallucinations | <input type="checkbox"/> racing thoughts |
| <input type="checkbox"/> intrusive thoughts | <input type="checkbox"/> thought disorder |
| <input type="checkbox"/> disorientation | <input type="checkbox"/> problems with judgment/planning |

Attention Problems

- | | |
|--|--|
| <input type="checkbox"/> difficulty completing task/distractible | <input type="checkbox"/> frequent forgetfulness |
| <input type="checkbox"/> difficulty focusing | <input type="checkbox"/> difficulty waiting your turn |
| <input type="checkbox"/> impulsiveness | <input type="checkbox"/> inability to concentrate |
| <input type="checkbox"/> not well organized | <input type="checkbox"/> hyperactivity |
| <input type="checkbox"/> short attention span | <input type="checkbox"/> problem with following instructions |

Behavior Problems

- | | |
|--|--|
| <input type="checkbox"/> oppositional/defiant behavior | <input type="checkbox"/> problems with legal authorities |
| <input type="checkbox"/> problems with peers | <input type="checkbox"/> inability to control temper |
| <input type="checkbox"/> involved in criminal justice system | <input type="checkbox"/> aggression/violent behavior |
| <input type="checkbox"/> fire setting | <input type="checkbox"/> torturing animals |
| <input type="checkbox"/> high risk sexual behavior | <input type="checkbox"/> stealing |
| <input type="checkbox"/> lying | <input type="checkbox"/> elopement from home |
| <input type="checkbox"/> self-mutilation | <input type="checkbox"/> uncooperative |
| <input type="checkbox"/> talks excessively | <input type="checkbox"/> minimal talk |

Academic Problems

- | | |
|---|---|
| <input type="checkbox"/> has trouble remembering | <input type="checkbox"/> loses track of time |
| <input type="checkbox"/> difficulty with problem solving | <input type="checkbox"/> forgets recent events |
| <input type="checkbox"/> becomes agitated when confronted with problems | <input type="checkbox"/> unable to stay on task |
| <input type="checkbox"/> difficulty with decision making | <input type="checkbox"/> trouble shifting tasks |
| <input type="checkbox"/> handles expectations poorly | <input type="checkbox"/> difficulty learning new tasks |
| <input type="checkbox"/> difficulty thinking through consequences | <input type="checkbox"/> too hyperactive to concentrate |
| <input type="checkbox"/> discourteous | <input type="checkbox"/> feels isolated from teacher/peer supports |
| <input type="checkbox"/> shy/withdrawn from classmates | <input type="checkbox"/> oppositional/defiant to authority figures |
| <input type="checkbox"/> aggressive toward classmates | <input type="checkbox"/> exhibits bizarre behaviors (if yes, specify below) |

Client Name:

Academic Problems (continued)

- | | |
|--|--|
| <input type="checkbox"/> tries to interact but does so inappropriately | <input type="checkbox"/> impulsivity |
| <input type="checkbox"/> frequent detentions/suspensions | <input type="checkbox"/> truancy |
| <input type="checkbox"/> reading/writing difficulty | <input type="checkbox"/> low self-esteem regarding abilities |
| <input type="checkbox"/> test anxiety | <input type="checkbox"/> slow to finish work |
| <input type="checkbox"/> reverses words/numbers | |
| <input type="checkbox"/> behaves as the "class clown" | <input type="checkbox"/> does not complete homework |

Additional comments:

Other Problem Areas

- | | |
|---|--|
| <input type="checkbox"/> obsessive behavior | <input type="checkbox"/> alcohol use |
| <input type="checkbox"/> elevated mood | <input type="checkbox"/> drug use |
| <input type="checkbox"/> somatic complaints | <input type="checkbox"/> learning disability |
| <input type="checkbox"/> victim of sexual abuse | <input type="checkbox"/> bed wetting past age 6 |
| <input type="checkbox"/> victim of neglect | <input type="checkbox"/> developmental disability/MR |
| <input type="checkbox"/> victim of physical abuse | <input type="checkbox"/> smoking |
| <input type="checkbox"/> victim of emotional trauma | <input type="checkbox"/> excessive spending |
| <input type="checkbox"/> gambling | <input type="checkbox"/> parent-child conflict |
| <input type="checkbox"/> confused/worried about sexual behavior | <input type="checkbox"/> staying up for days without sleep |
| <input type="checkbox"/> dizziness/blackouts | |

Strengths

- | | |
|--|--|
| <input type="checkbox"/> creative | <input type="checkbox"/> positive attitude |
| <input type="checkbox"/> artistic | <input type="checkbox"/> friendly |
| <input type="checkbox"/> athletic | <input type="checkbox"/> leader |
| <input type="checkbox"/> entrepreneurial | <input type="checkbox"/> enjoys reading |
| <input type="checkbox"/> street-wise | <input type="checkbox"/> enjoys writing |
| <input type="checkbox"/> common sense | <input type="checkbox"/> active in community |
| <input type="checkbox"/> outgoing | <input type="checkbox"/> team sports |
| <input type="checkbox"/> intelligent | <input type="checkbox"/> active in school activities |
| <input type="checkbox"/> musical talent | <input type="checkbox"/> physically fit |
| <input type="checkbox"/> positive interactions with family | <input type="checkbox"/> confident |
| <input type="checkbox"/> positive interactions with peers | <input type="checkbox"/> humorous |
| <input type="checkbox"/> independent | <input type="checkbox"/> academic achiever |
| <input type="checkbox"/> self-directed | <input type="checkbox"/> orderly |
| <input type="checkbox"/> emotionally stable | <input type="checkbox"/> helpful |
| <input type="checkbox"/> hobbies/interests (list): | |

Current general medical conditions (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> hypertension | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> endocrine (other) |
| <input type="checkbox"/> cardiac (other) | <input type="checkbox"/> cancer |
| <input type="checkbox"/> asthma | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> HIV | <input type="checkbox"/> stroke |
| <input type="checkbox"/> allergies (if yes, explain below) | <input type="checkbox"/> neurological (other) |
| <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> chronic lung disorder |
| <input type="checkbox"/> other significant systemic illness (specify) | |

Client Name:

Current general medical conditions (continued):

Additional comments:

Has there been a history of any of the following:

- head injury
- illness
- surgery
- anesthetic details

- high fever
- loss of consciousness
- poisoning
- personality changes

Primary Care Physician Information

Name _____

Address _____

Phone _____

Has the client been on any medications for behavioral/psychiatric treatment in the past?

Medication	Dosage	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Treatment:

<input type="checkbox"/> Psychiatric Hospitalization	If yes, date(s)	
<input type="checkbox"/> Individual Therapy	If yes, date(s)	
<input type="checkbox"/> Group Therapy	If yes, date(s)	
<input type="checkbox"/> Family Therapy	If yes, date(s)	
<input type="checkbox"/> Residential Treatment	If yes, date(s)	

Was the client's birth unusual in any way (premature, lack of oxygen)?

If yes, in what way? _____

Developmental Milestones (answer yes if the client accomplished the following in the given age ranges).

2-5 months

smiles, coos, watches faces, follows people/objects with eyes, laughs, lifts head while on stomach, independently holds head steady when pulled to sitting, grasps rattle, startles at loud sounds

Yes No

Comments

Client Name:

Developmental Milestones (answer yes if the client accomplished the following in the given age ranges).

6-9 months

babbles, combines vowel/consonant sounds (i.e. "dadada"), turns to locate source of sounds, responds to name, rolls over by self, sits with support/sits independently, transfers object from hand to hand, supports weight on feet when held to stand, uses thumb and fingers to pick up objects instead of whole-hand raking motion, crawls supporting weight on hands and knees

Yes

No

Comments

10-12 months

carry out simple verbal requests (I.e. waves "bye" when hearing word, purposefully says "mama"/"dada" as a greeting or to call parent, plays with object with both hands while sitting independently, pulls self to standing and cruise while holding furniture or adult's hand, picks up small objects with thumb and fingers, tries to communicate by reaching or pointing, visually/manually explores toys, recognizes familiar people, uses both hands

Yes

No

Comments

13-18 months

scribbles with large crayon, walks without assistance, feeds self finger foods, tries spoon feeding self, walks upstairs with one hand held, vocabulary of 4-10 words, follows simple directions to perform single task, responds to name, "talks" in long jabbering sentences as if having an understandable conversation, points to at least 2 pictures upon request, throws ball easily

Yes

No

Comments

Client's Home Situation:

Parents married

(how long)

Parents divorced

(date)

Foster care

One or more parent deceased

Living with relative other than parent(s):

(specify)

Residential placement

Other (specify)

Client Name:

Is there a family history of any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Incarceration |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Bipolar Disorder (Manic-Depression) | <input type="checkbox"/> Other mental illness |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Alcohol abuse |

Who in the family has the above history?

Father _____

Mother _____

Sibling(s) _____

Grandfather (paternal) _____

Grandmother (paternal) _____

Uncle/Aunt (paternal) _____

Grandfather (maternal) _____

Grandmother (maternal) _____

Uncle/Aunt (maternal) _____

Father's Education

- | | |
|---|---|
| <input type="checkbox"/> Some high school | <input type="checkbox"/> College graduate |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> Graduate degree |

Some college
Job/Profession _____

Learning difficulties (specify) _____

Mother's Education

- | | |
|---|---|
| <input type="checkbox"/> Some high school | <input type="checkbox"/> College graduate |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> Graduate degree |

Some college
Job/Profession _____

Learning difficulties (specify) _____

Siblings

Name	DOB	Gender
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Client Name:

How did you hear about the *Centers For Motivation, Inc.*?

Has the client had any previous psychological testing/assessments?

Test	Reason	Administrator	Date

Other pertinent information

Comments

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