# Hopewell Neuropsychological Center

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## Adult Intake

**Note:** You will have the opportunity to elaborate on anything mentioned here with your intake clinician and/or evaluator. If there is anything about which you would like them to ask you for more information, please feel free to indicate that.

| Today's Date: | Completed by: ☐ Self ☐ Other: |
|---|---|

**DEMOGRAPHICS**

| Name: | Sex: ☐ M ☐ F | Dominant Hand: ☐ R ☐ L ☐ Ambi |
|---|---|---|

| Date of Birth: | Age: | Cell Phone #: | Email: |
|---|---|---|---|

| Street Address | City | State | Zip Code | What is your first language? |
|---|---|---|---|---|

| Your race: ☐ Black/African American ☐ Asian ☐ Caucasian ☐ Latino ☐ American Indian/ Alaska Native ☐ Native Hawaiian/Other Pacific Islander | Marital status: ☐ Single ☐ Separated ☐ Partnered ☐ Divorced ☐ Married ☐ Widowed |
|---|---|

**YOUR PRESENT CONCERNS**

What issues (i.e., illness, injuries, etc.) led you to seek an evaluation **today** (or led someone to recommend one)?

What have **you** done to manage these difficulties?

**MENTAL HEALTH HISTORY**

Have you ever seen any of the following and reason? If so, please indicate when you saw them next to the checkmark and if your experience was helpful below.

☐ psychologist: ___________ ☐ psychiatrist: __________ ☐ counselor:___________ ☐ none

Have you ever had any of the following? If so, please indicate the date of the occurrence next to your answer.

☐ suicidal thoughts: _________________ ☐ thoughts of harming others: ___________________________

☐ attempted suicide: _________________ ☐ none

List all mental health/substance abuse, hospitalization, and outpatient treatments in the table below.

Check here if none ☐

| Date | Hospitalization or treatment (AA, Counseling, Group therapy, etc.) | Reason | Duration | Helpful? |
|---|---|---|---|---|
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List all previous neuropsychological or psychological testing in the table below.

Check here if none ☐

| Date | Reason for Testing | Diagnosis | Comments |
|---|---|---|---|
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Check all that apply to yourself or to immediate family members (e.g., grandparents, parents, siblings, or children)

Check here if none ☐

| Condition | You | Family | Which Family Member(s)? | Age/Date of Diagnosis |
|---|---|---|---|---|
| Anxiety | ☐ | ☐ | | |
| Bipolar Disorder | ☐ | ☐ | | |
| Depression | ☐ | ☐ | | |
| Post-traumatic stress (PTSD) | ☐ | ☐ | | |
| Borderline Personality Disorder (BPD) | ☐ | ☐ | | |
| Obsessive Compulsive Disorder (OCD) | ☐ | ☐ | | |
| Schizophrenia | ☐ | ☐ | | |
| Anger management problems | ☐ | ☐ | | |
| Alcohol abuse | ☐ | ☐ | | |
| Other substance abuse (please list): | ☐ | ☐ | | |
| Other: | ☐ | ☐ | | |
| Other: | ☐ | ☐ | | |
| Other: | ☐ | ☐ | | |
| Other: | ☐ | ☐ | | |
| Other: | ☐ | ☐ | | |

If you checked yes to any above, please provide additional details here:

## PHYSICAL HEALTH HISTORY

Do you need assistance with any of the following? Check here if none ☐

☐ Walking ☐ Household chores ☐ Cooking ☐ Bathing ☐ Other:

| Do you have any disabilities?<br>☐ vision ☐ hearing ☐ tremors<br>☐ Other: | Are you currently using any assistive devices such as<br>☐ glasses/contacts ☐ hearing aids ☐ walker<br>☐ Other: |
|---|---|

List all serious conditions, which include but is not limited to autoimmune disorders, heart disorders, endocrine disorders, etc. Check here if none ☐

| Conditions | Onset Date | Currently a problem? | Currently receiving treatment? |
|---|---|---|---|
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How many times have you received the following treatment cycles in your lifetime? Check here if none ☐

______ Chemotherapy ______ Radiation therapy

In the past two (2) years, how many times have you been under the following? Check here if none ☐

______ General anesthesia (date of last time): ______ Local anesthesia (date of last time):

List all the head injuries that you had in your lifetime below (assault, accident, sports, etc.) Check here if none ☐

| Date | Cause | Lost Consciousness? | When was medical treatment sought? | Dx from imaging |
|---|---|---|---|---|
| | | | ☐ immediate<br>☐ delayed (how long): | |
| | | | ☐ immediate<br>☐ delayed (how long): | |
| | | | ☐ immediate<br>☐ delayed (how long): | |
| | | | ☐ immediate<br>☐ delayed (how long): | |
| | | | ☐ immediate<br>☐ delayed (how long): | |

Does your condition(s) create problems in how you deal with life, including pain? If yes, please explain below.

## DEVELOPMENTAL HISTORY

If you know anything unusual or about any difficulties with prenatal, birth, postnatal care, or during early childhood, please describe below. Examples include premature birth, delays in walking/talking, etc. Check here if none ☐

Place of birth:

Were you adopted? ☐ No ☐ Yes (what age):

Where were you raised?

Who raised you?

Your parents are currently: ☐ married ☐ common-law spouse ☐ divorced since: ☐ other:

| Your Mother: | Your Father: |
|---|---|
| ☐ Living ☐ Deceased (year of death): | ☐ Living ☐ Deceased (year of death): |
| Occupation: | Occupation: |
| Education Level: | Education Level: |

How many siblings do you have? Check here if none ☐

_____ full brother ____ half-brothers ____stepbrothers ____ full sisters ____ half-sisters _____ stepsisters

Describe your early home life:

Have you ever been abused?

☐ physically ☐ mentally ☐ emotionally ☐ sexually ☐ never

Who abused you and how long did they do it for?

How old were you when this happened?

## SOCIAL FUNCTIONING

How often do you initiate conversations with other people?

Who do you talk to the most?

Who do you live with?

How many close friends do you have?

Have you ever been in a romantic, significant relationship?

Check here if none ☐

| # | Your age then | Duration | Married? | # of children | Reason for ending |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

Are you currently in a relationship? If so, please describe the relationship. Check here if none ☐

Do you have any children? Check here if none ☐

| Gender | Age: | Education Level: | Who do they live with? |
|---|---|---|---|
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## SUBSTANCE USE

List all the substances that you have tried or used in your lifetime below. Check here if none ☐

| Substance | Usage Duration | | | Usage Amount | |
|---|---|---|---|---|---|
| | Never | Age of 1st Use: | Date last used | Current Usage | Highest usage at any time |
| Tobacco | ☐ | | | | |
| Alcoholic products | ☐ | | | | |
| Marijuana | ☐ | | | | |
| Illicit Drugs: | ☐ | | | | |
| Other: | ☐ | | | | |
| Other: | ☐ | | | | |
| Other: | ☐ | | | | |

Has substance use affected you in any of these areas? Please describe below.

☐ work ☐ school ☐ relationships ☐ marriages

## EDUCATIONAL HISTORY

What is the highest educational level completed:

What were your typical high school grades:

Are you currently enrolled in an educational program?

☐ No ☐ Yes (list degree/major):

What types of problems did you have in school:

## LEGAL HISTORY

How many juvenile arrests have you had?

When and why were you arrested?

How many adult arrests have you had?

When and why were you arrested?

## OCCUPATIONAL HISTORY

What is the longest length of time you had at a single job?

What was your last job title and where was it at?

What types of jobs have you had?

## MILITARY SERVICE

Did you serve in the military? ☐ No (Please skip this section) ☐ Yes (Please list branch & date):

Was your service overseas? ☐ No ☐ Yes (Please list where):

Were you in combat? ☐ No ☐ Yes

What is your highest rank?

Did you serve in war time? ☐ No ☐ Yes (Please list what area):

Did you receive injuries or were ever exposed to any dangerous or unusual substances during your service (if yes, please explain)?

Do you hold a Purple Heart?

Please list any medals starting at Bronze Star Medal and above:

## MEDICATIONS TAKEN IN THE LAST 6 MONTHS

| Name | Dosage | Reason for Taking | Start Date | End Date |
|---|---|---|---|---|
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## YOUR OPINIONS & PLANS

Do you believe you have mental health issues?

Have your family & friends expressed any concerns about your mental health that is not mentioned above?

Is there anything else you would like us to know?