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Evaluation Intake Form

Patient Name:_____________________________ **Today's Date:** ________________

Patient DOB: __________ **Age:** ________

Ethnicity/Race:________________ **Gender:** __________

Address:____

Telephone #:___________________ **(mobile/home/work)**

Email: _________________________

May I leave a message on your voicemail? ☐Yes ☐No

May I email you regarding scheduling or appointment time information? ☐Yes ☐No

Emergency Contact Name:_________________ **Telephone #:** ________________

Please describe the primary reason(s) you are seeking an evaluation:

____

____

____

____

How did you find out about my office / who referred you?

____

****If form was not completed by Patient:**

Name of person who completed form and relationship to patient:

____

****If Patient is a child: Parent/Guardian Name and Phone Number:**

____

Medical History:

Current Primary Physician Name: ___________________________

Telephone: ____

Have you ever had any of the following conditions?				**Still a problem?**	
	Yes	**No**	**Year began**	**Yes**	**No**
Balance or falling problems	____	____	___________	____	____
Cancer	____	____	___________	____	____
Diabetes	____	____	___________	____	____
Dizziness	____	____	___________	____	____
Fainting spells	____	____	___________	____	____
Head Injury*	____	____	___________	____	____
Heart disease/heart attack	____	____	___________	____	____
High blood pressure	____	____	___________	____	____
Infection of the brain	____	____	___________	____	____
Kidney disease	____	____	___________	____	____
Lack of oxygen to the brain	____	____	___________	____	____
Lung disease	____	____	___________	____	____
Memory Loss	____	____	___________	____	____
Migraine of cluster headaches	____	____	___________	____	____
Multiple sclerosis	____	____	___________	____	____
Numbness	____	____	___________	____	____
Paralysis	____	____	___________	____	____
Parkinson’s disease	____	____	___________	____	____
Seizures, convulsions, epilepsy	____	____	___________	____	____
Sleep apnea	____	____	___________	____	____
Stroke	____	____	___________	____	____
Thyroid disease	____	____	___________	____	____
Transient ischemic attacks (TIA)	____	____	___________	____	____
Tremor	____	____	___________	____	____
Other, specify______________	____	____	___________	____	____

Have you experienced any blows to the head where you felt dazed, confused, disoriented, or were “seeing stars”? ***☐Yes ☐No***

- If yes, how many times?______________________
- If yes, did you lose consciousness during any of these events? ***☐Yes ☐No***

Current Medications:

Medicine, info of dosage: **For what condition?**

1.____

2.____

3.____

4.____

5.____

Have you had any surgeries or hospitalizations? ***☐Yes ☐No***

If yes, please provide details:

____

____

Birth and Developmental History:

Information requested pertains to the biological mother of the Patient. Did the mother receive prenatal care? ***☐Yes ☐No***

Did the mother experience any medical problems during pregnancy or during childbirth? Please describe.

____

____

Were expected developmental milestones in speech, language, social, fine motor, gross motor, & toileting skills? ____________ If no, please describe your concerns:

____

____

Did you receive any therapy services in early childhood? If yes, please indicate age at time of service and duration. Examples may include speech therapy, occupational therapy, or psychological therapy.

____

____

Family History:

Parent 1: ________________________ **Parent 2:**_______________________________

Educational level:_________________ **Educational Level:**______________________

Occupation:_______________________**Occupation:**____________________________

Do any of your biological relatives have the following conditions? (past/present)

	Mother	Father	Mother's Family	Father's Family	Siblings
Mental Retardation					
Autism					
Learning problems					
Attention problems					
Hyperactivity					
Epilepsy					
Alcoholism/Drug Abuse					
Memory Problems/ Dementia					
Depression					
Suicide Attempt(s)					
Anxiety Disorder					
Bipolar Disorder					
Schizophrenia					
Psychosis					
Criminal history					

Social History:

Current living situation:
□Alone □With partner/spouse □With children □With parents □With roommates

Current relationship status:
□ Single □ Married/Partnership □ Divorced □ Widowed □ Separated

Have you ever been abused in any of the following ways?
□ No Abuse □ Physical □ Verbal □ Sexual □ Emotional

Educational History:

Your highest level of formal education:_______________________

Degree(s) earned: (check all that apply)

_____GED
_____HS diploma
_____Associates degree
_____Bachelors degree
_____Masters degree
_____Doctoral degree

How were your grades in school?
□ above average (As and Bs)
□ average (Bs and Cs)
□ below average (Ds and Fs)

Occupational History:

Are you currently employed*: ☐Yes ☐No*

If yes, describe your current job:____
Length of employment?____

If no, which of the following circumstances apply:
□ Disabled, not able to work
□ Seeking compensation for injury
□ Seeking work
□ Retired, specify for how many years ____________
□ Other: specify _________________

Smoking History:

Do you smoke? ***☐Yes ☐No*** If yes, how many packs per day? _____________
If no, did you ever smoke? ***☐Yes ☐No*** Year quit? __________________

Alcohol/Drug History:

Do you drink alcohol?
☐Occasionally ☐ Regularly ☐ Never

How many drinks do you consume in a typical week? ____________________

Do you use "street" drugs?
☐Occasionally ☐Regularly ☐ Never

Have you had any of the following problems because of alcohol or other drugs?
☐Social, marital, or work problems ☐aggressive behavior (fighting) ☐legal problems

What is your usual bedtime?_______ What time do you usually arise?______________

Do you awaken feeling well rested? *☐Yes ☐No*

Do you take frequent daytime naps? *☐Yes ☐No*

Please check any of the concerns that you are having or have had:

Depression	Feeling hopeless	Trouble Concentrating
Memory Problems	Change in sleeping habits	Change in eating habits
Worrying/anxiety	Racing thoughts	Lack of energy
Panic attacks	Feeling nervous	Sudden feelings of panic
Muscle tension	Compulsive behaviors	Perfectionism
Self-esteem problems	Easily irritated	Feeling stressed
Memories of past trauma	Hallucinations	Suicidal/self-harm thoughts
Physical pain	Thoughts of harming others	Anger

Please add useful details regarding concerns checked above:

____
____
____
____

Are you currently experiencing any of the following emotional stressors?

□ Death/loss of loved one
□ Financial difficulty
□ Health problems
□ Job difficulties
□ Family/relationship problems
□ Other: ____________________

Please list your most frequent leisure activities and how often you are able to do these:

____

Is there anything that you hope to gain or learn as a result of this evaluation:

____
____
____

Thank you for taking the time to complete this form. Please ask any questions you have.