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Initial Evaluation Questionnaire

Name:

Age: **Date of Birth:** **Gender:**

Address:

Email Address:

Right | Left Handed:

Insurance Provider | Group Number | Member ID:

PRESENTING CONCERNS

What prompted you to seek this evaluation?

When did you first notice this issue?

Check all items you have tried to address this concern

- Therapy / Counseling
- Tutoring
- Meditation, yoga or other practices
- Support from friends
- Support from family
- Medication
- Diet / Supplements
- Pushing myself to do better
- Exercise
- Other strategies?

EDUCATIONAL BACKGROUND

Educational Level

How many years of education have you completed?

What is/was your area of study?

If attending school, your current GPA

Detail any difficulties you have in school?

Describe your early education experience

Planning to take the GRE, LSAT, MCAT or other type of qualifying exam? If so, which one?

EMPLOYMENT

Current Employment

What type of work do you do?

Detail any difficulties you have on the job

FAMILY BACKGROUND

Place of Birth

Where raised (if different from above)?

Who raised you?

Are your parents together or apart (if apart please explain)?

Parents education and employment

Please provide gender and age of your siblings

Does anyone in your family have concerns similar to yours?

How would your parents describe you?

Are you currently in a relationship?

Have any of your concerns affected your relationship, how?

Do you have children, if so, their gender and ages?

HEALTH SCREENING

Have you had any of the following?

- Migraine
- High blood pressure
- Heart disease
- Thyroid condition
- Broken bones
- Epilepsy or seizures
- Surgery
- Head Injury
- Injury resulting in a loss of consciousness
- Allergies (Allergy medication)
- Asthma
- Hearing problems
- Problems with vision
- Any other medial conditions?

Please list any medication you are prescribed and dosage?

Please list any health problems within your family

How often do you use nicotine?

How often do you use caffeine?

How often do you drink alcohol?

How often do you use other drugs (type)?

Have others mentioned use of the above substance appear to be a problem?

How many hours sleep do you get nightly on average?

Is your sleep restful?

Do you nap during the day?

Do you have difficulty:

- getting to sleep?
- staying asleep?
- waking up**?**

Do you take anything to assist your sleep?

How do you spend your leisure time?

Is it difficult to make friends?

Is it difficult to keep friends?

How would people that know you well describe your personality and social style?

What is your greatest concern?

What is your greatest hope or goal?

Thank you for completing this questionnaire. We can talk further regarding anything that was difficult to explain in writing.