



Intake Information Form

Please complete the following form to the best of your abilities. Your answers will provide us with information about your medical and psychosocial history. We are particularly concerned about characteristics or experiences that can affect thinking abilities and emotional functioning, so that we can take them into consideration in our assessment. Please answer the questions honestly and completely. Information will be kept confidential as indicated in the privacy notice. The doctor will review history with you, and you will have a chance to discuss your answers in detail and clarify any questions. Thank you!

A. Identification

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Gender: _____ Race/Ethnicity: _____
Highest grade completed: _____ Occupation: _____

B. Developmental History In which city/state were you born? _____

During your *mother's pregnancy* with you, did your mother have any of the following medical problems?

- Required bedrest or hospitalization for medical problems
- Used alcohol or other non-prescription drugs
- Used prescribed medication other than vitamins
- Smoked cigarettes
- Was exposed to lead, solvents, or other toxic substances
- Had high blood pressure due to pregnancy
- Suffered a serious physical injury
- Other _____

No problems during mother's pregnancy

I don't know

During *your birth*, were there any of the following problems or complications?

- Born prematurely
- Had the cord wrapped around your neck at birth
- Had forceps used during your delivery
- Lack of oxygen or other fetal distress
- Low "APGAR" scores (poor vital signs at birth)
- Treated in an infant Intensive Care Unit after your birth
- Other birth complications _____

No problems during my birth

I don't know

Did you experience any of the following delays in your *development* as a child?

- Walking late (after 1 ½ year of age)
- Talking late (after 2 years of age)
- Bedwetting (after 5 years of age)
- "Tics" (involuntary movements/sounds such as grunting)
- Social delays
- Other delays _____

Normal developmental milestones

I don't know

Do you have a childhood history of any of the following?

- Abuse
- Head Injury
- Seizures
- Speech Problems
- Learning disability
- ADD/ADHD
- Speech Therapy/Physical Therapy/Occupational Therapy (please circle)

C. Educational History Please briefly list information about your *high school and/or college/trade schools*

School Name Graduation Year Grades/~GPA Major Degree Any accommodations?

Best subject(s): _____ Worst subject(s): _____ Failed or repeated any grades? No Yes
SAT scores? _____ Any other known standardized test scores? _____

D. Occupational History

Currently Employed: No Yes. Briefly describe your *current and past employment* history:

Dates of employment Place of employment Job Title Job Duties Any job problems?

Have you done any kind of work where you were exposed to toxic chemicals? No Yes.

If yes, please explain dates, kinds of chemicals, kind of work and effects: _____

Military Service? No Yes Service Branch: _____ Rank at discharge: _____ Year of discharge: _____

Combat experience? No Yes Describe: _____

E. Medical History

Please list your current medical diagnoses: _____

Please list any surgeries and dates: _____

Have you had any of the following *neurological problems*?

- Head injury with loss of consciousness or confusion
- Seizures, epilepsy, or "fits"
- Stroke, brain hemorrhage, "TIA's" or other vascular problem
- High fever, meningitis, encephalitis, or other brain infection
- Fainting or dizzy spells?
- Brain tumor
- Loss of oxygen, choking, drowning, or suffocation
- Drug or alcohol overdose
- Severe or persistent headache, or migraine
- Parkinson's disease or other movement disorder
- Alzheimer's disease or other dementia
- Multiple sclerosis or other demyelinating disease
- Other neurologic disease _____

Have you had any of the following general *medical problems*?

- Allergies or asthma (please specify: _____)
- Heart attack or heart failure or any other heart disease (please circle)
- High blood pressure
- High cholesterol
- High blood sugar or diabetes
- Liver disease, hepatitis, cirrhosis, or jaundice
- Kidney disease or dialysis
- Thyroid disease or other endocrine (gland) disorder
- Vitamin deficiency
- Cancer
- Other medical problems _____

Have you ever had any of the following problems? If so, please specify when they started.

- Balance problems or falls. Specify: _____
- Tremors, dexterity problems or numbness in hands or legs. Specify: _____
- Vision problems (e.g. blurred, double, floaters, sensitivity). Specify: _____
- Hearing problems (e.g. hypersensitivity, ringing, interference). Specify: _____
- Taste changes (e.g. unusual or unexpected tastes). Specify: _____
- Smell problems (e.g. difficulty identifying odors, unusual/unexpected smells). Specify: _____
- Temperature regulation problems (e.g. feeling hot or cold all the time). Specify: _____
- Changes in sexual interest or activity. Specify: _____
- Incontinence with bladder or bowels. Specify: _____
- Depression. Specify: _____
- Anxiety. Specify: _____
- Hallucinations (seeing/hearing/feeling things that others don't). Specify: _____
- Delusions (strong beliefs that most others don't share). Specify: _____
- Other emotional difficulties. Specify: _____
- Car accidents. Specify: _____

List *all* medications, drugs, or other substances you are currently take or have taken in the last year—prescribed, over-the-counter vitamins, herbs, and others. If you have a list, you can provide a copy of the list.

<u>Medication/drug</u>	<u>Dose</u>	<u>How often?</u>	<u>Taken since</u>	<u>Reason to take it?</u>	<u>Prescribed by</u>	<u>Is it effective?</u>
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List any other relevant medications taken the past: _____

Have you had any of these diagnostic tests?

- MRI Date _____ Results _____
- CT Date _____ Results _____
- EEG Date _____ Results _____
- Labs Date _____ Results _____
- Sleep Study Date _____ Results _____

Have you ever received neuropsychological, psychological, psychiatric, drug or alcohol treatment, or counseling services before? No Yes. If yes, please indicate:

<u>When?</u>	<u>From whom?</u>	<u>For what?</u>	<u>With what results?</u>
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F. Health habits

Do you drink alcoholic beverages? No Yes

Current level of drinks per week: _____ Types of drinks consumed: _____

Do near relatives ever worry or complain about your drinking? No Yes

Have you ever neglected obligations, family, or work because you were drinking? No Yes

Have you ever been arrested for drunken driving or driving while intoxicated? No Yes

Have you ever used non-prescription drugs? No Yes. If Yes, Specify which ones:

- Barbiturates or "downers" (e.g. Seconal, Quaaludes, etc.) Opiates (e.g. heroin, methadone, Demerol, "smack") Amphetamines or "uppers" (e.g. Dexedrine, meth) or Cocaine or "crack" Marijuana or hashish
 Hallucinogens (e.g. LSD or "acid", PCP or "angel dust", etc.)
 Other _____

Do you consume coffee, soda, tea, or other sources of caffeine regularly? No Yes. # cups/cans per day _____

Do you consume tobacco? No Yes. # cigarettes/tobacco per day _____ If no, did you quit in the past? No Yes.

Are you satisfied with your sleep? No Yes. # hours of sleep/night _____ # daytime naps _____

Do you exercise regularly? No Yes. If yes, how often? _____ What type of exercise? _____

Do you have any legal history (e.g. law suits, arrests)? No Yes. If yes, please explain: _____

G. Family history

Mother: Alive? No Yes Age (or age at death): _____ Health problems?: _____ Job: _____

Father: Alive? No Yes Age (or age at death): _____ Health problems? _____ Job: _____

Brother(s): #: _____ Age(s): _____ Health problems? _____ Sister(s): #: _____ Age(s): _____ Health? _____

Your birth order: _____ of _____

Are you currently in a relationship? No Yes. How long? _____

Are you married? No Yes. How long?: _____ Prior divorces? No Yes. # of times: _____ When? _____

Would you describe your current marriage/relationship as Supportive Neutral Stressful Destructive None

Do you have children? No Yes. Names & ages: _____

Do your children have any behavioral or medical problems? No Yes. Type: _____

Does anyone in your *family* have a history of any of the following disorders? (check which ones)

Person affected

Seizures, epilepsy, or "fits"

Stroke, brain hemorrhage, "TIA's" or other vascular problem

Heart attack or heart failure or heart disease

Parkinson's disease or other movement disorder

Alzheimer's disease or other dementia

Genetic disorders

Liver disease, hepatitis, cirrhosis, or jaundice

Kidney disease or dialysis

Diabetes, thyroid disease or other endocrine (gland) disorder

Cancer. Specify type: _____

ADHD Learning Disability or Developmental Delays

Emotional problems (e.g. depression, anxiety, schizophrenia, bipolar, OCD). Please circle.

Problems with drugs or alcohol. Specify which: _____

Other serious medical or emotional problem? Specify: _____

Did you complete this form Independently or were you Helped by someone?

Thank you for providing this information. Dr. Irani will meet with you to discuss your history further.