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Case History Questionnaire

The information requested on this questionnaire is required as part of your evaluation. Please feel free to add as much information as you want. Use the backs of pages if necessary.

The highest standards of professional confidentiality are maintained. Information about any particular client can be released only with the explicit written consent of that person except in exceptional legal situations.

Today's Date: _____

Identifying Information

Your full name: _____

Preferred name: _____

Address: _____

_____

Birthdate: _____

Home Phone: _____ Cell Phone: _____

May we leave a message on your voice mail/machine? ☐ yes ☐ no

Gender: _____ Race/Ethnicity: _____

Marital Status: _____

Who is filling out (or helping you fill out) this form? _____

Have you ever been diagnosed with a learning disability? ☐ yes ☐ no

If yes, what type? _____

Have you ever been diagnosed with Attention Deficit Disorder, either with or without hyperactivity? ☐ yes ☐ no

If yes, ☐ with hyperactivity or ☐ without hyperactivity

What was the date of your last psychological evaluation? _____

Who conducted the evaluation? _____ **(Please provide copies of all reports.)**

Current Problems

What types of things are you currently struggling with in school or at work?

Are there particular classes, or subjects, or activities that are especially hard for you?

What are your strengths? What things you are particularly good at?

What do you like to do in your spare time?

Birth History (pertains to your biological mother's pregnancy with you)

Did your mother experience any of the following during her pregnancy with you?

Bleeding:.....☐ yes ☐ no

Illness:.....☐ yes ☐ no

Infections: .....☐ yes ☐ no

Accidents:.....☐ yes ☐ no

RH Incompatibility:☐ yes ☐ no

Length of Pregnancy:

Was the delivery ☐ early or ☐ on time or ☐ late

If delivery was late or early, by how much? _____

Were any medications taken by your mother during pregnancy? ☐ yes ☐ no

If yes, what? _____

Were there any unusual circumstances surrounding her pregnancy with you?

Labor and Delivery

Did your mother experience false labor? ☐ yes ☐ no

Was labor induced? ☐ yes ☐ no

How long was your mother in labor? _____

Type of Delivery?

Normal: .....☐ yes ☐ no

Breech: .....☐ yes ☐ no

Forceps:.....☐ yes ☐ no

Caesarean:.....☐ yes ☐ no

Birth weight: _____

Apgar score (if known): _____

Where there any unusual circumstances or complications during labor or delivery?

Condition of Baby:

Was your color normal? ☐ yes ☐ no

Were you blue? ☐ yes ☐ no

Were you jaundiced? ☐ yes ☐ no

Did you require any transfusions? ☐ yes ☐ no

Incubator required? ☐ yes ☐ no

If yes, for how long? _____

Difficulties sucking, swallowing or feeding? ☐ yes ☐ no

Please explain:

Developmental History

At what age did you:

Say your first word? _____

Sit unassisted? _____

Understand speech? _____

Walk unassisted?_____

Use 2-word sentences?_____

Stop using "baby" talk? _____

Did your family, friends, teachers, etc. ever have difficulty understanding your speech? ☐ yes ☐ no

If so, please explain:

What skills were hard for you to learn as a preschooler?

Did you tend to get in trouble frequently in school? ☐ yes ☐ no

What for: _____

Were you ever suspended or expelled from school? ☐ yes ☐ no

What for: _____

Medical History

Did you have any of these childhood medical problems?

Measles? ..... ☐ yes ☐ no Age _____ Explain: _____

Meningitis? ..... ☐ yes ☐ no Age _____ Explain: _____

Encephalitis? ..... ☐ yes ☐ no Age _____ Explain: _____

Whooping Cough? ..... ☐ yes ☐ no Age _____ Explain: _____

Scarlet Fever? ..... ☐ yes ☐ no Age _____ Explain: _____

Frequent ear Infections?..... ☐ yes ☐ no Age _____ Explain: _____

Chicken Pox? ..... ☐ yes ☐ no Age _____ Explain: _____

Pneumonia? ..... ☐ yes ☐ no Age _____ Explain: _____

Frequent Colds? ..... ☐ yes ☐ no Age _____ Explain: _____

Allergies? ..... ☐ yes ☐ no Age _____ Explain: _____

Other childhood illnesses? ..... ☐ yes ☐ no Age _____ Explain: _____

Have you ever received any blows to the head that required treatment in a hospital or emergency room? ☐ yes ☐ no

If yes, when? _____

Were you unconscious? ☐ yes ☐ no

If yes, for how long? _____

How did it happen?

Have you ever had seizures? ☐ yes ☐ no

At what age? _____

Did you receive medication? ☐ yes ☐ no Specify: _____

When was your last seizure? _____

Known cause for seizures? _____

Have you ever been diagnosed with or treated for stress, anxiety, depression, substance abuse, or other types of psychological problems?

As a child? ☐ yes ☐ no Specify: _____

As an adult? ☐ yes ☐ no Specify: _____

Have you ever had injuries or accidents requiring medical treatment? ☐ yes ☐ no

Specify: _____

Have you ever been hospitalized? ☐ yes ☐ no

When? _____

Length of hospitalization(s)? _____

Purpose? _____

Were there any changes in thinking, behavior, or school performance following illnesses, blows to head, seizures, injuries or hospitalizations? ☐ yes ☐ no

Specify: _____

_____

_____

Current Medical Condition

Describe your present health.

Are you presently on medication? ☐ yes ☐ no

Current Medications	Amount	Frequency	Treatment Duration	Reason

Are you allergic to any drugs? ☐ yes ☐ no Please specify: _____

How is your appetite? _____

Do you have food allergies? ☐ yes ☐ no Please specify: _____

Are you trying to gain or lose weight? ☐ gain ☐ lose ☐ neither

Have you recently had any changes in your weight? ☐ gained ☐ lost ☐ neither

What is your height: _____ Current weight: _____

How many hours do you typically sleep each night? _____

Is this adequate for you to function well? ☐ yes ☐ no

Do you have difficulty sleeping? ☐ yes ☐ no

Do you wear glasses or contact lens? ☐ yes ☐ no

When was your last eye exam? _____

Have you used any of the following substances?

Substance	Current Use: *please check which of these you have used in the past 6 months*			**If you have ever** used this substance, at what age did you ***first*** use it?			
	Never	Sometimes	Often	12 or under	13-17	18-22	> 22
Caffeine							
Cigarettes							
Beer							
Wine or wine coolers							
Liquor							
Marijuana							
Cocaine or crack							
Hallucinogens (e.g. LSD)							
Uppers (non prescription)							
Downers (non prescription)							
Heroin or opiates							
Designer Drugs							
Inhalants							
Methamphetamine							

Family Background

If you are married, please provide this information about your spouse

Name: _____

Occupation: _____

Highest level of education: _____

Work or cell phone: _____

Children

Do you have children? ☐ yes ☐ no

Please list your children below.

Child's Name	Age	Highest level of education	Any Disability

Continue on an additional sheet if necessary.

Father's Information (pertains to your biological father)

Name: _____

Home Phone: _____

Address: _____

Work/cell Phone: _____

Occupation: _____

Educational Level: _____

Difficulties in learning? ☐ yes ☐ no Describe: _____

Other disabilities (e.g., physical, psychological)?

Describe: _____

Mother's Information (pertains to your biological mother)

Name: _____

Home Phone: _____

Address: _____

Work/cell Phone: _____

Occupation: _____

Educational Level: _____

Difficulties in learning? ☐ yes ☐ no Describe: _____

Other disabilities (e.g., physical, psychological)? Describe: _____

Siblings

Do you have sisters and brothers? ☐ yes ☐ no

Sibling's Name	Age	Education Level / Occupation	Any Disability

Continue on additional sheet if needed

Other Significant Information About Your Family

Please indicate the existence of any of these conditions in your family. Indicate the relationship of the person to you (e.g., father, maternal grandmother):

Mental Health Disorders ..... ☐ yes ☐ no Who? _____ What? _____

Mental Retardation ..... ☐ yes ☐ no Who? _____ What? _____

Epilepsy ..... ☐ yes ☐ no Who? _____

Other Neurological Disorder ..... ☐ yes ☐ no Who? _____ What? _____

Autism Spectrum Disorder ..... ☐ yes ☐ no Who? _____ What? _____

Serious Chronic Illness ..... ☐ yes ☐ no Who? _____ What? _____

Speech/Language Problems ..... ☐ yes ☐ no Who? _____ What? _____

Substance Abuse ..... ☐ yes ☐ no Who? _____ What? _____

Trouble with the Law ..... ☐ yes ☐ no Who? _____ What? _____

What languages are spoken in your home? _____

What language did you learn first? _____

At what age did you begin to learn English? _____

How often has your family moved? _____

Is anyone in your immediate family left handed? ☐ yes ☐ no

Who? _____

Educational Background

Elementary and Secondary School History

Did you attend public or private schools? _____

How many schools did you attend? _____

Indicate when moves took place. _____

_____

_____

Did you repeat any grades in school? ☐ yes ☐ no Specify: _____

What things were hard for you in elementary school?

High School

What things were hard for you in junior high and high school?

Did you / will you graduate high school? ☐ yes ☐ no Graduation date? _____

Did you earn a GED? ☐ yes ☐ no Graduation date? _____

High school grade point average? _____

Best S.A.T. scores (if taken): _____ Verbal : _____ Math: _____

Was test: ☐ Standard Time ☐ Extended Time

Best A.C.T. scores (if taken):

Was test: □ Standard Time □ Extended Time

In high school, did you take a Foreign Language? □ yes □ no

# of semesters: _____ Foreign Language: _____ Course grade earned: _____

# of semesters: _____ Foreign Language: _____ Course grade earned: _____

# of semesters: _____ Foreign Language: _____ Course grade earned: _____

Please provide a copy of high school transcript

Special Education Services or Tutoring

Did you receive any special education services in school? ☐ yes ☐ no

Which years? _____

Did you have an IEP or 504 Plan? ☐ yes ☐ no _____

Which years? _____

Did you attend resource classes? ☐ yes ☐ no

Which years? _____

Did you attend self-contained classes? ☐ yes ☐ no

Which years? _____

Did you attend a school or program for students with special needs? ☐ yes ☐ no

Which years?_____

Did you attend any other types of academic support programs? ☐ yes ☐ no

Which years?_____

Specify type, duration and dates of attendance: _____

_____

Describe tutoring you have had (subjects, hours/week):

What help did you find the most beneficial and why?

History of Learning Difficulties

What things are currently most difficult for you?

When was your problem first observed?

Evaluations related to your learning difficulties (list chronologically).

Date	Examiner	Place	Diagnosis

Please include copies of your previous evaluations for summary in this evaluation.

Have you ever had any of the following medical evaluations? Specify diagnosis and give date.

EEG ..... ☐ yes ☐ no Diagnosis/Date: _____

CT/MRI ..... ☐ yes ☐ no Diagnosis/Date: _____

Neurological examination .. ☐ yes ☐ no Diagnosis/Date: _____

Other: . Diagnosis/Date: _____

College History

Colleges and/or Technical Schools Attended (indicate dates):

College Currently Attending:

List Current Courses:

Have you taken any Learning Support (or remedial) classes in college? ☐ yes ☐ no

If yes, which areas? ☐ Reading ☐ English ☐ Math

Will you need to take any Learning Support classes? ☐ yes ☐ no

Are you required to take foreign language courses for your degree? ☐ yes ☐ no ☐ don't know

In college, have you taken or are you currently taking?

Math/College Algebra? ..... ☐ yes ☐ no # of semesters _____ grade earned _____

English Composition? ..... ☐ yes ☐ no # of semesters _____ grade earned _____

Foreign Language? ..... ☐ yes ☐ no # of semesters _____ grade earned _____

What are your best subjects? _____

What are your poorest subjects? _____

Current Cumulative G.P.A.: _____

Major: _____

Class Status: ☐ freshman ☐ sophomore ☐ junior ☐ senior ☐ graduate

Anticipated Graduation Date: _____

Please provide copy of college transcripts

Work History

List all salaried and volunteer positions beginning with the most recent.

Position / Job	Where	Time Period	Major Responsibilities

Have you ever been fired from a job? ☐ yes ☐ no

Have you ever received a negative performance evaluation? ☐ yes ☐ no

Have you ever been, or are you currently involved in any legal difficulties? ☐ yes ☐ no

Specify: _____

Are you a veteran of the armed forces? ☐ yes ☐ no

Dates of service: _____

Current Plans

What are you hoping to do in the next few years, personally or professionally?

If there is anything that you think is important for us to know about you in order to understand the difficulties you are having in school, please provide that information here: