Gail Kalin, Ph.D.
Licensed Psychologist

Intake Questionnaire

In order to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. There is a lot of information and you may not remember or have access to all of it; do the best you can. This information is confidential. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information but indicate so verbally.

Name _____ First Appointment Date _____

Birth Date _____ Age _____ Sex _____

Address _____

City _____ State ____ Zip _____

Home Phone # _____

Work # _____

CELL #: _____

Who are you currently living with? _____

REFERRAL SOURCE _____

Phone #_____ Fax: _____

Do I have your permission to release information to the referring professional when it is appropriate?
Yes ____ No _____ Other: _____ N/A

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____

_____

_____

_____

_____

_____

_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

_____

_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY
(Please include contact with other professionals, medications, types of treatment, what was helpful, etc.)

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)

Cultural/Ethnic/Religious Background

Describe yourself

Describe your strengths

Describe your weaknesses

Describe your relationships with friends

HISTORY

Prenatal and birth events: Your parents attitude toward their pregnancy with you _____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc_____
Any birth problems, trauma, forceps or complications?: _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

_____

_____

School History: Last grade completed _____ Last school attended _____
Average grades received _____ Specific learning disabilities _____
Learning strengths _____
Any behavior problems in school? _____
What have teachers said about you _____

Employment History: (summarize jobs you've had, list most favorite and least favorite)

_____

_____

Any work-related problems? _____

What would your employers or supervisors say about you? _____

Military History? _____

Ever Any Legal Problems? _____

Family Structure (who lives in your current household, please give relationship to each):

_____

_____

_____

Current Marital or Relationship Satisfaction_____

_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)_____

_____

_____

History of Past Marriages _____

_____

Your Children (names, ages, problems, strengths) _____

_____

Home Atmosphere Growing Up: _____

_____

_____

_____

Raised by Natural, Adoptive or Step Parents? _____ **What ages were you?** _____

_____

_____

Natural Mother's History: age_____ Profession: _____

Describe her personality: _____

_____

Describe her relationship to you: _____

_____

School: highest grade completed _____

Learning problems _____ Behavior problems _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc)_____

_____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

_____

Mother's alcohol/drug use history _____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

Natural Father's History: age_____ Profession: _____

Describe his personality: _____

_____

Describe his relationship to you: _____

_____

School: highest grade completed _____

Learning problems _____ Behavior problems _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc)_____

_____

_____

_____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

_____

Father's alcohol/drug use history _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

If Applicable, Adoptive or Step Mother's History: Age____ Profession: _____

Describe her personality: _____

_____

Describe her relationship to you: _____

_____

School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____

_____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

_____

Mother's alcohol/drug use history _____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

If Applicable: Adoptive or Step Father's History: Age____ Profession: _____

Describe his personality: _____

_____

Describe his relationship to you: _____

_____

School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____

_____

_____

_____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

_____

Father's alcohol/drug use history _____
Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

Sexual history: (answer only as much as you feel comfortable)
Age at the time of first sexual experience: _____ Number of sexual partners: _____
Any history of sexually transmitted disease? _____ History of abortion? _____
History of sexual abuse, molestation or rape? Yes _____ No: _____
By Whom: Your Age then?

Current sexual issues or problems? _____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. _____

Ever experience withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning? _____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____

MEDICAL HISTORY

Past medical problems/medications: _____

Other doctors/clinics seen regularly: _____

Any history of head trauma? (describe): _____

Any history of being unconscious: _____

Ever any seizures or seizure like activity? _____

Prior medical hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc: _____

Allergies/drug intolerances (describe): _____

Present Height _____ *Present Weight* _____

Current medications including psychiatric medications: _____

_____

_____

Prescribing doctor(s): _____

_____

_____

Phone: _____ Fax: _____ Email? _____

Address: _____

_____

Do I have permission to contact this doctor if necessary regarding your medication, diagnosis, or treatment?

Yes: ____ No: _____ Comments: _____

Current supplements/vitamins/herbs: _____

_____

_____

Previous Psychiatric Hospitalizations? _____ How many times? _____ Age(s)? _____

Why were you hospitalized? _____

What was your experience of being hospitalized? _____

_____

_____

_____

Anything you feel I should know about you or your history?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name: _____ **Date:** _____ **Age:** _____

Amen Adult General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well (Can be done on another answer sheet). List other person and relationship to you:_____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other	Self	
____	___	1. depressed or sad mood
____	___	2. decreased interest in things that are usually fun, including sex
____	___	3. significant weight gain or loss, or marked appetite changes, increased or decreased
____	___	4. recurrent thoughts of death or suicide
____	___	5. sleep changes, lack of sleep or marked increase in sleep
____	___	6. physically agitated or "slowed down"
____	___	7. low energy or feelings of tiredness
____	___	8. feelings of worthlessness, helplessness, hopelessness or guilt
____	___	9. decreased concentration or memory
____	___	10. periods of an elevated, high or irritable mood
____	___	11. periods of a very high self esteem or grandiose thinking
____	___	12. periods of decreased need for sleep without feeling tired
____	___	13. more talkative than usual or pressure to keep talking
____	___	14. racing thoughts or frequent jumping from one subject to another
____	___	15. easily distracted by irrelevant things
____	___	16. marked increase in activity level
____	___	17. excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures)
____	___	18. panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month ____)
____	___	19. periods of trouble breathing of feeling smothered
____	___	20. periods of feeling dizzy, faint or unsteady on your feet
____	___	21. periods of heart pounding or rapid heart rate
____	___	22. periods of trembling or shaking
____	___	23. periods of sweating
____	___	24. periods of choking
____	___	25. periods of nausea or abdominal upset
____	___	26. feelings of a situation "not being real"
____	___	27. numbness or tingling sensations
____	___	28. hot or cold flashes
____	___	29. periods of chest pain or discomfort
____	___	30. fear of dying
____	___	31. fear of going crazy or doing something uncontrolled
____	___	32. avoiding everyday places for fear of having a panic attack or needing to go with other people in order to feel comfortable
____	___	33. excessive fear of being judged by others which causes you to avoid or get anxious in situations
____	___	34. persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list _____
____	___	35. recurrent bothersome thoughts, ideas or images which you try to ignore
____	___	36. trouble getting "stuck" on certain thoughts, or having the same thought over and over
____	___	37. excessive or senseless worrying
____	___	38. others complain that you worry too much or get "stuck" on the same thoughts
____	___	39. compulsive behaviors that you must do or you feel very anxious, such as excessive hand

washing, checking locks, or counting or spelling

___ ___ 40. needing to have things done a certain way or you become very upset
___ ___ 41. others complain that you do the same thing over and over to an excessive degree (eg., cleaning or checking)
___ ___ 42. recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.) please list _____
___ ___ 43. recurrent distressing dreams of a past upsetting event
___ ___ 44. a sense of reliving a past upsetting event
___ ___ 45. a sense of panic or fear to events that resemble an upsetting past event
___ ___ 46. you spend effort avoiding thoughts or feelings associated with a past trauma
___ ___ 47. persistent avoidance of activities/situations which cause remembrance of upsetting event
___ ___ 48. inability to recall an important aspect of a past upsetting event
___ ___ 49. marked decreased interest in important activities
___ ___ 50. feeling detached or distant from others
___ ___ 51. feeling numb or restricted in your feelings
___ ___ 52. feeling that your future is shortened
___ ___ 53. quick startle
___ ___ 54. feels like you're always watching for bad things to happen
___ ___ 55. marked physical response to events that remind you of a past upsetting event, i.e., sweating when getting in a car if you had been in a car accident
___ ___ 56. marked irritability or anger outbursts
___ ___ 57. unrealistic or excessive worry in at least a couple areas of your life
___ ___ 58. trembling, twitching or feeling shaky
___ ___ 59. muscle tension, aches or soreness
___ ___ 60. feelings of restlessness
___ ___ 61. easily fatigued
___ ___ 62. shortness of breath or feeling smothered
___ ___ 63. heart pounding or racing
___ ___ 64. sweating or cold clammy hands
___ ___ 65. dry mouth
___ ___ 66. dizziness or lightheadedness
___ ___ 67. nausea, diarrhea or other abdominal distress
___ ___ 68. hot or cold flashes
___ ___ 69. frequent urination
___ ___ 70. trouble swallowing or "lump in throat"
___ ___ 71. feeling keyed up or on edge
___ ___ 72. quick startle response or feeling jumpy
___ ___ 73. difficult concentrating or "mind going blank"
___ ___ 74. trouble falling or staying asleep
___ ___ 75. irritability
___ ___ 76. trouble sustaining attention or being easily distracted
___ ___ 77. difficulty completing projects
___ ___ 78. feeling overwhelmed of the tasks of everyday living
___ ___ 79. trouble maintaining an organized work or living area
___ ___ 80. inconsistent work performance
___ ___ 81. lacks attention to detail
___ ___ 82. makes decisions impulsively
___ ___ 83. difficulty delaying what you want, having to have your needs met immediately
___ ___ 84. restless, fidgety
___ ___ 85. make comments to others without considering their impact
___ ___ 86. impatient, easily frustrated
___ ___ 87. frequent traffic violations or near accidents
___ ___ 88. refusal to maintain body weight above a level most people consider healthy
___ ___ 89. intense fear of gaining weight or becoming fat even though underweight
___ ___ 90. feelings of being fat, even though you're underweight
___ ___ 91. recurrent episodes of binge eating large amounts of food
___ ___ 92. a feeling of lack of control over eating behavior

____ ___ 93. engage in regular activities to purge binges, such as self induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise

____ ___ 94. persistent overconcern with body shape and weight

____ ___ 95a. involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have motor tics been present?_____ How often?_____ describe_____

____ ___ 95b. involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, swearing). How long have verbal tics been present?_____ How often?_____ describe_____

____ ___ 96. delusional or bizarre thoughts (thoughts you know others would think are false)

____ ___ 97. seeing objects, shadows or movements that are not real

____ ___ 98. hearing voices or sounds that are not real

____ ___ 99. periods of time where your thoughts or speech were disjointed or didn't make sense to you or others

____ ___ 100. social isolation or withdrawal

____ ___ 101. severely impaired ability to function at home or at work

____ ___ 102. peculiar behaviors

____ ___ 103. lack of personal hygiene or grooming

____ ___ 104. inappropriate mood for the situation (i.e., laughing at sad events)

____ ___ 105. marked lack of initiative

____ ___ 106. frequent feelings that someone or something is out to hurt you or discredit you

____ ___ 107. do you snore loudly (or do others complain about your snoring)

____ ___ 108. have others said you stop breathing when you sleep

____ ___ 109. do you feel fatigued or tired during the day

____ ___ 110. do you often feel cold when others feel fine or they are warm

____ ___ 111. do you often feel warm when others feel fine or they are cold

____ ___ 112. do you have problems with brittle or dry hair

____ ___ 113. do you have problems with dry skin

____ ___ 114. do you have problems with sweating

____ ___ 115. do you have problems with chronic anxiety or tension

____ ___ 116. impairment in communication as manifested by at least one of the following:

- delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
- in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- repetitive use of language or odd language
- lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

____ ___ 117. impairment in social interaction, with at least two of the following:

- marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- failure to develop peer relationships appropriate to developmental level
- lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- lack of social or emotional reciprocity

____ ___ 118. repetitive patterns of behavior, interests, and activities, as manifested by at least one of following:

- preoccupation with an area of that is abnormal either in intensity or focus
- rigid adherence to specific, nonfunctional routines or rituals
- repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupation with parts of objects

Name_____ Age _____ Date _____

Amen Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other _____

0 Never | 1 Rarely | 2 Occasionally | 3 Frequently | 4 Very Frequently | NA Not Applicable/Not Known

Other	Self		
____	___	1.	Fails to give close attention to details or makes careless mistakes
____	___	2.	Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork)
____	___	3.	Trouble listening
____	___	4.	Fails to finish things
____	___	5.	Poor organization for time or space (such as backpack, room, desk, paperwork)
____	___	6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
____	___	7.	Loses things
____	___	8.	Easily distracted
____	___	9.	Forgetful
____	___	10.	Poor planning skills
____	___	11.	Lack clear goals or forward thinking
____	___	12.	Difficulty expressing feelings
____	___	13.	Difficulty expressing empathy for others
____	___	14.	Excessive daydreaming
____	___	15.	Feeling bored
____	___	16.	Feeling apathetic or unmotivated
____	___	17.	Feeling tired, sluggish or slow moving
____	___	18.	Feeling spacey or "in a fog"
____	___	19.	Fidgety, restless or trouble sitting still
____	___	20.	Difficulty remaining seated in situations where remaining seated is expected
____	___	21.	Runs about or climbs excessively in situations in which it is inappropriate
____	___	22.	Difficulty playing quietly
____	___	23.	"On the go" or acts as if "driven by a motor"
____	___	24.	Talks excessively
____	___	25.	Blurts out answers before questions have been completed
____	___	26.	Difficulty waiting turn
____	___	27.	Interrupts or intrudes on others (e.g., butts into conversations or games)
____	___	28.	Impulsive (saying or doing things without thinking first)
____	___	29.	Excessive or senseless worrying
____	___	30.	Upset when things do not go your way
____	___	31.	Upset when things are out of place
____	___	32.	Tendency to be oppositional or argumentative
____	___	33.	Tendency to have repetitive negative thoughts
____	___	34.	Tendency toward compulsive behaviors
____	___	35.	Intense dislike for change
____	___	36.	Tendency to hold grudges
____	___	37.	Trouble shifting attention from subject to subject
____	___	38.	Trouble shifting behavior from task to task
____	___	39.	Difficulties seeing options in situations
____	___	40.	Tendency to hold on to own opinion and not listen to others
____	___	41.	Tendency to get locked into a course of action, whether or not it is good
____	___	42.	Needing to have things done a certain way or you become very upset
____	___	43.	Others complain that you worry too much
____	___	44.	Tend to say no without first thinking about question
____	___	45.	Tendency to predict fear
____	___	46.	Frequent feelings of sadness

47. Moodiness
48. Negativity
49. Low energy
50. Irritability
51. Decreased interest in others
52. Decreased interest in things that are usually fun or pleasurable
53. Feelings of hopelessness about the future
54. Feelings of helplessness or powerlessness
55. Feeling dissatisfied or bored
56. Excessive guilt
57. Suicidal feelings
58. Crying spells
59. Lowered interest in things usually considered fun
60. Sleep changes (too much or too little)
61. Appetite changes (too much or too little)
62. Chronic low self-esteem
63. Negative sensitivity to smells/odors
64. Frequent feelings of nervousness or anxiety
65. Panic attacks
66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
67. Periods of heart pounding, rapid heart rate or chest pain
68. Periods of trouble breathing or feeling smothered
69. Periods of feeling dizzy, faint or unsteady on your feet
70. Periods of nausea or abdominal upset
71. Periods of sweating, hot or cold flashes
72. Tendency to predict the worst
73. Fear of dying or doing something crazy
74. Avoid places for fear of having an anxiety attack
75. Conflict avoidance
76. Excessive fear of being judged or scrutinized by others
77. Persistent phobias
78. Low motivation
79. Excessive motivation
80. Tics (motor or vocal)
81. Poor handwriting
82. Quick startle
83. Tendency to freeze in anxiety provoking situations
84. Lacks confidence in their abilities
85. Seems shy or timid
86. Easily embarrassed
87. Sensitive to criticism
88. Bites fingernails or picks skin
89. Short fuse or periods of extreme irritability
90. Periods of rage with little provocation
91. Often misinterprets comments as negative when they are not
92. Irritability tends to build, then explodes, then recedes, often tired after a rage
93. Periods of spaciness or confusion
94. Periods of panic and/or fear for no specific reason
95. Visual or auditory changes, such as seeing shadows or hearing muffled sounds
96. Frequent periods of deja vu (feelings of being somewhere you have never been)
97. Sensitivity or mild paranoia
98. Headaches or abdominal pain of uncertain origin
99. History of a head injury or family history of violence or explosiveness
100. Dark thoughts, may involve suicidal or homicidal thoughts
101. Periods of forgetfulness or memory problems

Amen Clinic Learning Disability Screening Questionnaire

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person (such as a spouse, partner or parent) rate you as well. List other person_____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other Self

Reading

____ ___ 1. I am a poor reader.
____ ___ 2. I do not like reading.
____ ___ 3. I make mistakes when reading like skipping words or lines.
____ ___ 4. I read the same line twice.
____ ___ 5. I have problems remembering what I read even though I have read all the words.
____ ___ 6. I reverse letters when I read (such as b/d, p/q).
____ ___ 7. I switch letters in words when reading (such as god and dog).
____ ___ 8. My eyes hurt or water when I read.
____ ___ 9. Words tend to blur when I read.
____ ___ 10. Words tend to move around the page when I read.
____ ___ 11. When reading I have difficulty understanding the main idea or identifying important details.

Writing

____ ___ 12. I have "messy " handwriting.
____ ___ 13. My work tends to be messy.
____ ___ 14. I prefer print rather than writing in cursive.
____ ___ 15. My letters run into each other or there is no space between words.
____ ___ 16. I have trouble staying within lines.
____ ___ 17. I have problems with grammar or punctuation.
____ ___ 18. I am a poor speller.
____ ___ 19. I have trouble copying off the board or from a page in a book.
____ ___ 20. I have trouble getting thoughts from my brain to the paper.
____ ___ 21. I can tell a story but cannot write it.

Body Awareness/ Spatial Relationships

____ ___ 22. I have trouble with knowing my left from my right.
____ ___ 23. I have trouble keeping things within columns or coloring within lines.
____ ___ 24. I tend to be clumsy, uncoordinated.
____ ___ 25. I have difficulty with eye hand coordination.
____ ___ 26. I have difficulty with concepts such as up, down, over or under.
____ ___ 27. I tend to bump into things when walking.

Oral Expressive language

____ ___ 28. I have difficulty expressing myself in words.
____ ___ 29. I have trouble finding the right word to say in conversations.
____ ___ 30. I have trouble talking around a subject or getting to the point in conversations.

Receptive language

____ ___ 31. I have trouble keeping up or understanding what is being said in conversations.
____ ___ 32. I tend to misunderstand people and give the wrong answers in conversations.
____ ___ 33. I have trouble understanding directions people tell me.
____ ___ 34. I have trouble telling the direction sound is coming from.
____ ___ 35. I have trouble filtering out background noises.

Math

____ ___ 36. I am poor at basic math skills for my age (adding, subtracting, multiplying and dividing)
____ ___ 37. I makes "careless mistakes" in math.
____ ___ 38. I tend to switch numbers around.
____ ___ 39. I have difficulty with word problems.

Sequencing

____ ___ 40. I have trouble getting everything in the right order when I speak.
____ ___ 41. I have trouble telling time.
____ ___ 42. I have trouble using the alphabet in order.
____ ___ 43. I have trouble saying the months of the year in order.

Abstraction

____ ___ 44. I have trouble understanding jokes people tell me.
____ ___ 45. I tend to take things too literally.

Organization

____ ___ 46. My notebook/paperwork is messy or disorganized.
____ ___ 47. My room is messy.
____ ___ 48. I tend to shove everything into my backpack, desk or closet.
____ ___ 49. I have multiple piles around my room.
____ ___ 50. I have trouble planning my time.
____ ___ 51. I am frequently late or in a hurry.
____ ___ 52. I often do not write down assignments or tasks and end up forgetting what to do.

Memory

____ ___ 53. I have trouble with my memory.
____ ___ 54. I remember things from long ago but not recent events.
____ ___ 55. It is hard for me to memorize things for school or work.
____ ___ 56. I know something one day but do not remember it to the next.
____ ___ 57. I forget what I am going to say right in the middle of saying it.
____ ___ 58. I have trouble following directions that have more than one or two steps.

Social Skills

____ ___ 59. I have few or no friends.
____ ___ 60. I have trouble reading body language or facial expressions of others.
____ ___ 61. My feelings are often or easily hurt.
____ ___ 62. I tend to get into trouble with friends, teachers, parents or bosses.
____ ___ 63. I feel uncomfortable around people I do not know well.
____ ___ 64. I am teased by others.
____ ___ 65. Friends do not call and ask me to do things with them.
____ ___ 66. I do not get together with others outside of school or work.

Scotopic Sensitivity

____ ___ 67. I am light sensitive. Bothered by glare, sunlight, headlights or streetlights.
____ ___ 68. I become tired, experience headaches, mood changes, feel restless or an inability to stay focused with bright fluorescent lights.
____ ___ 69. I have trouble reading words that are on white, glossy paper.
____ ___ 70. When reading words or letters shift, shake, blur, move, run together, disappear or become difficult to perce
____ ___ 71. I feel tense, tired, sleepy, or even get headaches with reading
____ ___ 72. I have problems judging distance and have difficulty with such things as escalators, stairs, ball sports, or dr

Sensory Integration Issues

____ ___ 73. I seem to be more sensitive to the environment than others.
____ ___ 74. I am more sensitive to noise than others.
____ ___ 75. I am particularly sensitive to touch or very sensitive to certain clothing or tags on the clothing.
____ ___ 76. I have unusual sensitivity to certain smells.
____ ___ 77. I have unusual sensitivity to light.
____ ___ 78. I am sensitive to movement or crave spinning activities?
____ ___ 79. I tend to be clumsy or accident-prone.

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General

- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other_____

Neurological

- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other_____

Respiratory

- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other_____

Chest and Cardiovascular

- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other_____

Head, Eye, Ear, Nose, & Throat

- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other_____

Gastrointestinal and Hepatic

- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other_____

Musculoskeletal

- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other_____

Skin, Hair

- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other_____

Genitourinary

- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other_____

Females

- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other_____

Males

- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other_____

Explanation