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Self-Report Questionnaire for Young Adults

Please answer the following questions carefully and completely. Your answers will help us greatly in our understanding of yourself. The questionnaire will be reviewed with you, so it will be possible to discuss your answers.

Name: _____ Today's Date _____
Nickname _____ Age: _____ Date of Birth: _____
Name of legal guardians: _____
Day phone: _____ Cell phone: _____
Mailing Address: _____
Email: _____

Reason for Referral
Please list, in order of urgency, the problem(s) you are experiencing:

A. _____

B. _____

C. _____

D. _____

Family Situation

Who are you currently living with? *Please Circle*

alone with parents

with roommates with spouse

other living arrangement: _____

Family of Origin

Who did you reside with growing up?

_____

Pregnancy

1. Age of parents at time of your birth: mother _____ father _____

2. While your mother was pregnant, did she have any of the following difficulties?

_____ spotting or bleeding

_____ frequent nausea or vomiting

_____ swelling or toxemia

_____ preeclampsia/eclampsia

_____ high blood pressure

_____ clotting disorder

_____ thyroid problems

_____ diabetes

_____ kidney disease

_____ pneumonia

_____ headaches

_____ flu, infections, high fever

_____ hospitalization prior to delivery

_____ very overweight

_____ very underweight

_____ measles/rubella

_____ venereal disease

_____ heart trouble

_____ nervous

_____ worried

_____ depressed

_____ family problems

_____ marital problems

_____ financial problems

_____ accidents/ injuries_____

_____ surgeries_____

_____ medications _____

_____ alcohol intake _____

_____ drug use _____

_____ exposure to toxic chemicals or substances _____

_____ stressful events for one or both parents _____

_____ other social problems _____

Delivery

1. Were you full term? _____ If not, how many weeks premature? _____

2. Birth weight _____

3. Length of hospital stay for mother? _____ Length of stay for you? _____

Was any of the following present during or soon after delivery?

_____ mother was put to sleep _____ baby was jaundiced (yellow)

_____ C-section performed _____ baby aspirated meconium (breathed waste)

_____ instruments used to deliver _____ baby needed blood

_____ RH factor present _____ baby needed oxygen

_____ breech birth or presentation _____ baby had trouble sucking

_____ born with cord around neck _____ baby had trouble keeping food down

_____ baby was blue

_____ baby was placed in an incubator. If yes, how long?_____

_____ other medical problems at birth (*describe)* _____

_____

4. Is there a family history of the following: (*please indicate who – parent, sibling, maternal grandfather, etc.)*

Autism	Intellectual disability (MR)
Learning disabilities/Dyslexia	Depression
ADD/ADHD	Bipolar/Schizophrenia
Anxiety	Other _____
Congenital or Chromosomal Abnormalities	Speech or language delay

Developmental History

1. Were there any concerns with your early development in areas of:

motor development: _____

language development: _____

social development: _____

3. Estimate the age at which the following occurred:

Age		Age	
_____	smiled	_____	spoke first words
_____	held head up	_____	spoke in phrases
_____	sat unsupported	_____	spoke in sentences
_____	crawled	_____	toilet-trained- bladder
_____	took first steps	_____	toilet-trained- bowel
_____	walked alone	_____	dressed self

Medical Information

1. Did you have any serious illnesses, injuries, or hospitalizations? _____

If yes, please describe:

Age Description

_____

_____

_____

_____

2. Please write the ages (in years) that your had any of the following illnesses from beginning of the illness to end:

Ages	Ages	Ages
_____ allergies	_____ head injuries	_____ pneumonia
_____ asthma	_____ heart trouble	_____ prolonged colic
_____ blood transfusion	_____ high fevers	_____ tonsillitis/strep
_____ seizures	_____ major fractures	_____ tics, twitching
_____ diabetes	_____ menstrual problems	_____ frequent ear infections
_____ meningitis	_____ loss of consciousness	_____ PE (ear) tubes
_____ tonsillectomy	_____ adenoidectomy	_____ Other:

3. The physician who referred you for evaluation is _____

4. Your present medications are _____

5. Please list therapies currently receiving _____

_____

6. Please list any past therapies: _____

7. Results of most recent exam:

Vision: normal corrected with glasses / contacts / vision therapy

Hearing: normal corrected with hearing aids / PE tubes

7. Have you had an MRI done in the past?_____

8. Have you had any chromosomal or genetic testing, and if so, what were the results?

_____

9. Please describe your present eating habits. (Note any problems in these areas).

_____

_____

10. Do you eat a variety of foods? _____

Are you on any special Diets? _____

Do you have any known food allergies? _____

Do you have irregular bowel patterns or difficulty with constipation or reflux?

_____

Do you have any weight concerns (over or under weight)? _____

_____

11. Please describe your present sleep habits. (Please note any problems in going to sleep, sleeping alone, night awakenings, length of sleep, nightmares, sleep walking, etc.)

_____

_____

_____

Usual bed time _____ Wake time _____ Daytime sleeping? _____

School History

1. Highest grade completed _____

3. Please list below the schools attended:

School	Location (City, State)	Ages/ Grades
_____		
_____		
_____		
_____		

4. Did you ever repeated a grade? _____ If yes, what grade and what was the reason?

_____

_____

5. Please write the grade in which you may have received any of the following services in the school setting:

_____ Head Start

_____ PPCD

_____ Section 504 plan

_____ Early Reading Program (Title I)

_____ Speech Therapy

_____ Physical Therapy

_____ Occupational Therapy

_____ School Counselor

_____ Resource Room

_____ Self-Contained Classroom

_____ Special Education Services

_____ Inclusion Services

If you were in special education, please circle the eligibility category

Speech Impairment

Autism

Learning Disability

Intellectual Disability

Emotionally Disturbed

Traumatic Brain Injury

Other Health Impaired

Other: _____

Please list any academic subjects that were addressed with these services _____

_____

_____

_____

_____

6. Did you struggle in school in any of the following areas? *Please Circle*

Reading	Written Expression	Math
Spelling	Science/Social Studies	Handwriting

7. Describe any academic or work place problems you are currently experiencing.

_____

_____

8. Have you had any previous psychological or neuropsychological testing? If so, by whom and when?

_____

_____

9. Do you have any previous diagnoses? If so, please explain. _____

_____

_____

Social Functioning

1. Compared to others, how well do you:

		Circle one	
Get along with family members:	Worse	Same	Better
Get along with peers/co-workers	Worse	Same	Better
Follow rules/laws	Worse	Same	Better
Work Independently	Worse	Same	Better
Keep up with responsibilities	Worse	Same	Better
Keep workspace/living space clean	Worse	Same	Better

2. How do you relate to others? *(Place checkmark next to words that describe you)*

_____ affectionate	_____ fun-loving	_____ self-conscious
_____ annoys	_____ generous	_____ selfish
_____ cruel	_____ impulsive	_____ serious
_____ curious	_____ jealous	_____ shy
_____ easily angered	_____ lazy	_____ show-off
_____ easily embarrassed	_____ lonely	_____ suspicious
_____ easily mislead	_____ mean	_____ teases
_____ easily upset	_____ no friends	_____ tense
_____ fearful	_____ quiet	_____ trusting
_____ fights	_____ resentful	_____ withdraws
_____ friendly	_____ rough	

3. How do you relate to family members? *(Place checkmark next to words that describe you)*

_____ afraid	_____ helpful	_____ tries to please
_____ angry	_____ hits	_____uncontrollable
_____ asks for help	_____ ignores	_____ uncooperative
_____ bosses	_____ pouts	_____ withdraws
_____ comforts	_____ seeks attention	_____ yells
_____ cooperative	_____ shares feelings	_____ cries
_____ talks back	_____easily controlled	_____ tells lies

4. Please list your strengths, talents, and special abilities (what are you best at?): _____

_____

_____

5. Please describe any unusually positive or negative relationships you have with important people in your life: _____

_____

_____

6. Please provide any additional information that will assist the examiner in obtaining relevant information regarding your difficulties _____

_____

_____

_____