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ADULT QUESTIONNAIRE

Today's Date: _____

Your Full Name: _____
First Middle Last

Date of Birth: ____/____/____ Age: _____ Gender: Male Female

Address: _____
Street Apt. Number

City State County Zip Code Phone Number

Employer: _____
Company City

Job Title () Work Phone Number

I am a (circle one): full-time student part-time student not attending school

If applicable, please list the current school you are attending: _____

Current grade level in school: _____

Father's Name: _____ Age: _____ Home Phone: () _____
First Last

Father's Address (if different from above): _____
Street Apt. #

City State County Zip Code

Father's employer: _____
Company City

Job Title () Work Phone Number

Mother's Name: _____ Age: _____ Home Phone #: (____) _____
First Last

Mother's Address (if different from above): _____
Street Apt. #

City State County Zip Code

Mother's employer: _____
Company City

Job Title Work Phone Number

REASON FOR REFERRAL:

How did you hear about me? _____

Who recommended this treatment/evaluation and why? _____

What do you wish to accomplish through undergoing this treatment/evaluation?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

What are your strengths, talents, and interests? (Circle all that apply)

- | | | | |
|-----------------------|----------------|--------------------------------|-------------------------|
| Reading aloud | Social Studies | Learning quickly | Well-liked |
| Reading comprehension | Science | Remembering information | Social skills |
| Spelling | Mathematics | Ability to think before acting | Making/keeping friends |
| Writing stories | Handwriting | Planning/Organizational skills | Sports |
| Language Arts/English | Drawing | Ability to stay on task | Self-confidence |
| Listening skills | Arts/crafts | Completing homework quickly | Building things |
| Speaking skills | | Creating new ideas | Processing info rapidly |

Other: _____

What are your problem areas? (Circle all that apply)

- | | | | |
|-----------------------|----------------|--------------------------------|------------------------|
| Reading | Social Studies | Learning slowly | Low self-esteem |
| Spelling | Science | Remembering information | Social skills |
| Writing stories | Mathematics | Act before thinking | Making/keeping friends |
| Language Arts/English | Handwriting | Planning/Organizational skills | Uncooperative |
| Listening skills | Drawing | Unfocused, can't stay on task | Sports |
| Speaking skills | Behavior Prbs. | Easily Distracted | Arts/crafts |
| Sleeping | Worried | Completes homework slowly | Building things |
| Eating | Sad | Easily overwhelmed | Time management |
| | Drinking/drugs | Processing information slowly | Financial management |

Other: _____

What are your interests, hobbies, and career goals?: _____

PREGNANCY COMPLICATIONS

	Not True	True	Don't Know
Alcohol use, specify:			
Cigarette smoking:			
Narcotic or illicit drug use, specify:			
Pre-eclampsia			
Eclampsia (toxemia)			
Placenta previa			
Medication(s) prescribed (list med. and for what problem)			
Bleeding/ infection/trauma in the ___ month of pregnancy			
Multiple births (twins, triplets, etc.)			
Other:			

LABOR AND DELIVERY

	Not True	True	Don't Know
Long labor			
Labor was induced			
Forceps/suction used			
Delivery performed under general anesthesia			
Cesarean section (due to breech positioning, fetal distress, failure to progress, repeat C, etc.)			
Injury to infant during delivery, specify:			
Infant was blue at birth			
Other:			

City, State where I was born: _____

I was born: full-term/on time early (specify # weeks ___) late (specify # weeks ___)

At birth, I was considered: healthy / in need of special medical care.

ATTAINMENT OF EARLY DEVELOPMENTAL MILESTONES

With regard to when you learned how to walk, talk, etc., please circle "on time" or "delayed" as appropriate.

Language	on time / delayed on time / delayed	First words Put two words together
Motor	on time / delayed on time / delayed on time / delayed	Walked independently Jumping skills Fine motor: drawing, buttoning, tying shoelaces
Adaptive	on time / delayed	Use spoon, dress self, toilet training

SUBSEQUENT MEDICAL HISTORY

	Not TRUE	TRUE	Relevant Details (age, severity, evaluations, etc.)
Trouble with vision			
Trouble with hearing			
Frequent ear infections			
Allergies			
Asthma			
Pneumonia			
Seizures, fits, convulsions, absence spells			
Automobile Accidents			
Slow weight gain			
Excessive weight gain			
Failure to thrive			
Meningitis / Encephalitis			
Anemia (low blood count)			
Lead exposure / poisoning			
Cardiac problems			
Kidney problems			
Headaches/Migraines			
Streptococcal Infections			
Birthmarks / Café au lait spots on skin			
Other:			

	Relevant Dates / Ages	Brief Description
Accidents/Injuries		
Surgeries (include ear tubes)		
Visits to the Emergency Room and hospitalizations		
(Broken bones, head injuries, concussions, loss of consciousness, cuts requiring stitches, etc.)		
CT Scans, MRIs, EEGs, EKGs		
Other stressful events since high school:		

Do you wear corrective lenses to improve your visual acuity? Yes / No

Do you wear hearing devices to improve your hearing? Yes / No

Name and location of primary care physician: _____

PREVIOUS MEDICAL / PSYCHOLOGICAL DIAGNOSES

If you have been evaluated by a neurologist, endocrinologist, or medical / mental health professional (neuropsychologist, psychologist, psychiatrist, etc.), please list the diagnosis or diagnoses that have been made.

Previous Evaluation / Diagnosis	Diagnosis made by (name, title)	Age when diagnosis was made

Have you been involved in counseling or psychotherapy in the past or currently? Yes / No

MEDICATION HISTORY

Please list any medications you have taken to treat problems related to sadness/depression, mood swings, worrying/anxiety, attention/concentration, getting along with other people, and/or other psychological/psychiatric issues.

Name of Medication	Problem area	Dose/Freq.	Began (mo/yr)	Stopped (mo/yr)	Helpful?	Neg. Side Effects?

EDUCATIONAL HISTORY

	Name of School	City, State
Kindergarten		
First Grade		
Second Grade		
Third Grade		
Fourth Grade		
Fifth Grade		
Sixth Grade		
Seventh Grade		
Eighth Grade		
Ninth Grade		
Tenth Grade		
Eleventh Grade		
Twelfth Grade		
Undergraduate		
Graduate		

SAT Scores: _____ ACT Scores: _____

By the end of high school, my Grade Point Average (GPA) was: _____

Undergraduate GPA: _____

Graduate GPA: _____

During elementary, middle, or high school, did you receive special educational services in school?

Circle one: Yes / No

If applicable, the kind of special educational services I received in school included: (circle all that apply)

- Content mastery
- Resource room services
- Placement in a full-time, self-contained special educational classroom
- 504 Plan
- Speech/Language Therapy
- Occupational Therapy / Physical Therapy
- Other: _____

In my educational career after high school (e.g., at junior college or college), I received accommodations at school for having Learning Disabilities, Attention-Deficit/Hyperactivity Disorder (ADHD/ADD), and/or other psychiatric conditions.

Circle one: Yes / No

Please list your current classes and grades: _____

Amount of time I spend on homework each day: _____

Where do you usually do homework?: _____

EMPLOYMENT HISTORY

Since I left high school, I have earned money by working at a job: Yes / No

If yes, please complete the following table and begin with the first job you had since high school. Therefore, the last job listed is your current position. If more space is needed, use back of paper.

	Job Title	Place of Employment	Date Started (month/year)	Date Ended (month/year)	Hours worked per week
First Job					
Second Job					
Third Job					

Fourth Job					
Fifth Job					
Sixth Job					

My current annual income is: \$ _____ per year

FAMILY CONSTELLATION

Marital Status (circle all that apply): single, married, divorced, remarried, widowed

(Circle all that apply): I live alone or

with parents / siblings / spouse / other family members / roommates.

Are you receiving financial support from your family?: Yes / No

If yes, circle one of the following:

My family pays for _____ % (<25%, 50%, 75%, or 100%) of my living expenses.

Biological parents are: Married Separated Divorced Remarried
 Single Mother Deceased Father Deceased

Name(s) and age(s) of my brother(s) please indicate if half- or step-brother(s):

Name(s) and age(s) of my sister(s), please indicate if half- or step-sister(s):

(if applicable)

Step-mother's age: _____ highest level of education completed: _____.

Present occupation: _____ Employer: _____

Step-father's age: _____ highest level of education completed: _____

Present occupation: _____ Employer: _____

SOCIAL HISTORY

Please describe how you spend your free time: _____

How do you usually spend your weekends?: _____

During the week, when do you usually go to bed and awaken in the morning?: _____

Do you have trouble falling asleep?: Yes / No

Do you have trouble staying asleep?: Yes / No

When you awaken in the morning, do you feel rested?: Yes / No

Do you usually take naps during the day?: Yes / No

LEGAL HISTORY

Have you ever been in trouble with the law?: Yes / No

How many speeding tickets have you gotten?: _____

How many motor vehicle accidents have you been involved in?: _____

Have you ever been convicted of a misdemeanor?: Yes / No

Felony?: Yes / No

FAMILY MEDICAL HISTORY

Please list family members who have experienced the following problems. Use additional space below table, if necessary.

Condition	List all family members who have this condition/prb.
Problems learning to read	
Problems learning to spell	
Problems learning to write	
Problems learning mathematics	
Problems focusing/organizing as a child	
Attention-Deficit/Hyperactivity Disorder	
Oral Language Disorder	
Speech articulation problem/disorder	
Mental Retardation	
Slow Development	
Seizures / Epilepsy	
Tics / Tourette's Syndrome	
Endocrine Problems	
Musculoskeletal Problems	
Hearing/Vision Problems	
Drinking problem or drug abuse	
Depression, anxiety, or other psychological problem: _____	
Behavior problems in childhood/adolescence	
Early death	
Other:	

END OF QUESTIONNAIRE. THANK YOU.