PREMIER PSYCHOLOGICAL
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ADULT ASSESSMENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Name of person completing this questionnaire and relationship to the patient: _____

_____

General Medical Doctor:

_____

Special Medical Providers:

_____

Referral Information

Person who referred you for evaluation:

_____

Reason for this evaluation: _____

_____

Are you seeking other services: ☐ Social Security Disability ☐ Medicaid Waiver
☐ Vocational Rehabilitation ☐ Legal Compensation ☐ Other: _____

Duration of symptoms: _____

Circumstances/factors you think are important regarding the evaluation:

_____

_____

What are your major difficulties: _____

_____

_____

Describe some of your strengths: _____

_____

_____

Does anyone else in the family have a problem similar to your reason for referral:

_____

Family Information

Current Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Other

Children's first names and ages:

Others living in home:

Are there any significant family or marital, relationship, or family conflicts:

What supports do you currently have in your life: CHECK ALL THAT APPLY

☐ Maternal Grandparents	☐ Sisters/Spouses	☐ Community Groups
☐ Paternal Grandparents	☐ Friends	☐ Other: _____
☐ Brothers/Spouses	☐ Religious Community	☐ Other Relatives:

Developmental History

Describe any known health problems of your mother's during pregnancy:

☐ Smoking ☐ Alcohol ☐ Illicit Drugs ☐ Prescription Medications
☐ Depression or Other Emotional Problems ☐ Gestational Diabetes ☐ Injury ☐ Other

Please explain any checked boxes: _____

As a child did you receive: ☐ Physical Therapy ☐ Occupational Therapy
☐ Sensory Integration Therapy ☐ Speech and Language Therapy
If checked, please explain reasons, dates, and providers _____

Other language spoken at home (besides English): _____

Psychiatric / Mental Health / Behavior

Has the client seen a counselor or psychologist before: ☐ Yes ☐ No
If yes, who, when, and for what reason(s): _____

_____

_____

_____

Current or Psychiatric Diagnoses: _____

_____

_____

_____

History of self-harm: ☐ Yes ☐ No
If yes, please explain: _____

History of physical, sexual, or emotional abuse: ☐ Yes ☐ No
If yes, please explain: _____

Alcohol and drug use: ☐ Yes ☐ No
If yes, please explain: _____

History of hospitalization for psychiatric reasons: ☐ Yes ☐ No
If yes, please explain: _____

Previous or current contact with any social agency, psychiatrist, clinic or private agency ☐ Yes ☐ No

Name of Professional	Address	Dates	Reason

Please describe any family history of psychiatric problems:

_____

_____

Any other comments you would like to make:

_____

_____

Prior Neuropsychological/Psychological Evaluation: ☐ Yes ☐ No

Name of Professional	Address	Dates	Reason

Medical History

Has your vision been checked: ☐ Yes ☐ No ☐ Normal Eyeglasses or Contact Lens
☐ Corrective Eye Surgery

Has your hearing been checked: ☐ Yes ☐ No ☐ Normal ☐ Tubes ☐ Corrective Ear Surgery
Hearing aide ☐ Please explain any vision or hearing difficulties/ surgeries: _____

_____

_____

List any medical conditions, neurological or developmental disorders, or genetic syndromes:

_____

_____

_____

_____

Do you have a history of head injury: ☐ Yes ☐ No
☐ Loss of Consciousness ☐ Emergency Treatment
Please describe:

_____

_____

Please describe behavior, learning, or cognitive changes after the injury: _____

_____

_____

Did you receive: ☐ CT ☐ MRI ☐ EEG
Reason and results: _____

_____

_____

Other tests and results: _____

_____

_____

List serious illnesses/injuries/hospitalizations/surgeries:

Date	Incident (explain)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is there a history of: Check C or F (C=Client F= family)

C	F		C	F	
☐	☐	Failure-to-Thrive	☐	☐	Repetitive/Stereotypic Movements (e.g., hand flapping)
☐	☐	Seizures	☐	☐	Impulsivity
☐	☐	Epilepsy	☐	☐	Temper Tantrums
☐	☐	Staring or Blank Spells	☐	☐	Nail Biting
☐	☐	Lead Poisoning/Toxic Ingestion	☐	☐	Clumsiness
☐	☐	Meningitis or Encephalitis	☐	☐	Head Banging
☐	☐	Asthma or Allergies	☐	☐	Self-Injurious Behavior
☐	☐	Diabetes	☐	☐	Genetic Disorders
☐	☐	Loss of Consciousness	☐	☐	Neurological Disorder
☐	☐	Abdominal Pains/Vomiting	☐	☐	Psychiatric Disorder
☐	☐	Headaches	☐	☐	Inattention
☐	☐	Frequent Ear Infections	☐	☐	Hyperactivity
☐	☐	Ear Tubes	☐	☐	Emotional problems (e.g., anxiety, depression, bi-polar)
☐	☐	Sleep Difficulties	☐	☐	Mental retardation/ developmental disability
☐	☐	Eating Difficulties or Eating Disorder			
☐	☐	Tics/Twitching			

Please describe any items checked (relationship to client, length of time, how treated):

_____

_____

Current Medications:	Reason:	Prescribing Practitioner:

Previous Medications:	Reason:	Prescribing Practitioner:

Educational History

Highest or current grade in school: _____

School Progress: _____

_____

_____

_____

Vocational / Technical Training: _____

College: _____

Describe any specialized academic instruction or tutoring you received: (Please be specific):

_____

_____

_____

Individual Education Plan (IEP) ☐ Yes ☐ No Please explain if checked yes: _____

_____

_____

_____

Individual Service Provider (ISP) ☐ Yes ☐ No Please explain if checked yes: _____

_____

_____

_____

Any grades that were skipped or repeated:

_____

Please explain any problems reported by teachers:

_____

Please describe any academic strengths and difficulties that you had during school:

_____

_____

_____

_____

_____

Is there a history of learning difficulty/ disorder in any family member: ☐ Yes ☐ No

_____

_____

Specific problems noted:

_____

Employment History

Current Employer: _____

Type of Work / Job Duties: _____

_____

Previous Type of Work / Job Duties: _____

_____

_____

_____

Legal History

☐ None ☐ Tickets ☐ Pending Charges ☐ Arrests ☐ Incarcerations ☐ Lawsuit ☐ Other

Please provide further information for any boxes checked (When? Where? What? Disposition?):

_____

_____

_____

_____

_____

****PLEASE BRING COPIES OF ANY REPORTS OF PSYCHOLOGICAL OR EDUCATIONAL EVALUATIONS THAT ARE AVAILABLE****