Hawkins & Ball

LIFE HISTORY QUESTIONNAIRE
& NEUROPSYCHOLOGICAL REFERRAL FORM
Self-Report Form

The purpose of this questionnaire is to obtain a comprehensive personal history and the current status for you. By completing these questions as fully and as accurately as you can, you will greatly facilitate our assessment and therapeutic programs. We ask you to answer the questions on your own time instead of using up actual consulting time.

It is understandable that you may be concerned about what happens to this information, because much or all of this material is personal. By law, case records are highly confidential. *No outsider is permitted to see a client's case record without client's or guardian's written permission, except as required under highly unusual circumstances by state or federal law*. Generally, these circumstances entail the abuse of a child or an older person, or in cases in which an order for records has been issued by a state or federal judge. Requirements to release confidential records are usually stronger in matters of criminal law (e.g., a serious crime) than in civil law (e.g., a divorce or custody suit, or suit for damages). Our office does not release records on the strength of a subpoena issued by an attorney, without written consent for disclosure, but of course we must release records if ordered to do so by a judge. We will make every effort to contact you before acting should any such subpoena or court order be directed toward us concerning your records. If you care not to answer a question, merely write, "Do not care to answer." If a question is not applicable, write "N/A." If you do not know an answer, write "DK." Many questions may not be relevant to your history. Again, just write "N/A" for those. Feel free to write on the backs of the pages as needed. We prefer that you complete this form by hand and in ink.

1. General: Date:_____

Client Last Name	First Name	Middle Name	Family ("Maiden") Name
Current Client Age:	Date of Birth:	Place of Birth (optional):	Country of Citizenship (optional):
Client's Social Security Number:	Home Phone:	Work Phone:	Cell Phone:
e-mail Address 1:	e-mail Address 2:	Other Location Information (Specify):	
Street Address:	City:	State:	Zip Code:

Print the names of other persons who assisted in completing this questionnaire (if any), specifying their relationship to you:

Name of Person Assisting	Relationship to the Client	How Long Has This Assistant Known the Client?	Interest in the Referral Question
1.			
2.			
3.			

2a. Referral Question:

Who referred you to our office? _____

What is the main referral question or issue? Why do you seek services from our office? State in your own words the nature of the problem or problems which prompted you to contact the psychologist or counselor:

_____

_____

_____

_____

_____

_____

_____

Give a brief account of the history and development of the problem condition, including any periods when you were free of the problem:

_____

_____

Describe the specific things that you do, or that you have been told that you do, which are relevant to the presenting problem:

_____

_____

Describe any emotional issues that are relevant to the referral problem: _____

_____

Describe any of your thought processes that appear to be related to the referral issue: _____

_____

How do these behaviors, thoughts, and/or feelings affect your life, your relationships with others, and your social and physical world? _

_____

_____

_____

_____

How long have these behaviors and other aspects of the problem been present? _____

What do you see as the most important causes of your problems? _____

_____

_____

Rate the severity of your problems as you see them on the scale below from 1 (mildly upsetting) through 3 to (very severe) 5 (totally incapacitating):

1 2 3 4 5

When and how did you or anyone close to you notice the behavior, thoughts, or emotions that have led to this referral? _____

_____

Who is most concerned about this referral issue? _____

Why is this issue of such importance? _____

_____

What do you, or any other interested parties hope to get from our services? _____

_____

2b. Assessment/Intervention History:

PSYCHOLOGICAL/PSYCHIATRIC TREATMENT HISTORY

Dates of Service, Start to Finish	Professional's Name	Specialty (e.g., psychiatry)	Address	Phone	Diagnosed Condition(s) Under Treatment	How Long Treated? Successful?

PSYCHOLOGICAL/PSYCHIATRIC ASSESSMENT HISTORY

Date of Assessment Report	Professional's Name	Specialty (e.g., clinical psychology)	Address	Phone	Diagnosed Condition(s)	Changes Resulting from Findings

PSYCHIATRIC HOSPITALIZATIONS

Hospital	City & State	Condition(s) Under Treatment	Approximate Admission Date	How Long Treated?

When in school did you receive special education services based on a "full individual evaluation" provided by the school's special education department or on an "independent educational evaluation" provided by an independent professional team?

□ YES
□ NO
□ DON'T KNOW or UNSURE

If YES, for what disabling condition(s) did you receive such services?
□ a reading disorder or dyslexia (specific learning disorder or disability)
□ a mathematics disorder or dyscalculia (specific learning disorder or disability)
□ dysgraphia or other writing disorder (specific learning disorder or disability)
□ traumatic brain injury (TBI)
□ emotional/behavioral disorder (ED or EBD)
□ autism spectrum disorder (ASD)
□ intellectual developmental disorder or disability (IDD)
□ other handicapping condition: attention-deficit/hyperactivity disorder (ADHD)
□ other handicapping condition: specify: _____

Have you ever been diagnosed with any of these difficulties or another psychiatric disorder outside an educational context?
□ YES
□ NO
□ DON'T KNOW or UNSURE

If YES, please provide details and dates:

3. Physical and Health

PRE- AND PERINATAL HISTORY

How many live births to your mother before your birth?_____ After this one?_____

Total Number of pregnancies (including live births, miscarriages, and induced abortions) your biological mother has had:_____

Detail any complications with the pregnancy that led to your birth:

Check as many of the following items as you know to be true of the pregnancy, labor, delivery, and immediate post-delivery period in this person's life. If you check an item, please write what you know about the particulars, using the back of the page, as necessary.

□ Maternal infectious illness that might affect embryo or fetus (the unborn baby)

- □ Toxoplasmosis
- □ Cytomegalovirus infection
- □ Rubella (German measles)
- □ Bacterial infection of the vagina
- □ Urinary tract infections
- □ Herpes simplex
- □ Chicken pox
- □ Listeriosis
- □ Others (specify)

□ Systemic difficulties

- □ Maternal anemia
- □ Gestational diabetes
- □ Preeclampsia (toxemia of pregnancy)
- □ Eclampsia
- □ Maternal anemia
- □ Others (specify)

□ Threats of miscarriage

- □ Placenta previa (placenta covering the cervix)
- □ Placental abruption (premature detachment of the placenta)
- □ Rh incompatibility
- □ Maternal trauma
- □ Maternal bleeding
- □ Maternal surgery

□ Maternal temperature over 103° F

□ Maternal leg swelling

□ Maternal blood clotting

□ Typical pregnancy sickness (morning sickness)

□ Extreme maternal nausea and vomiting

□ Maternal consumption of alcohol (specify how much of what kind of alcohol, how often, and when during the pregnancy)

□ Maternal illicit drug use (specify how much of what drugs, how often, and when during the pregnancy)

□ Maternal medications (specify how much of what medications, how often, and when during the pregnancy)

□ Others (specify)

Detail any complications with the labor or delivery that led to your birth:

□ Premature rupturing of the membranes (water breaking)

□ Preterm (premature) labor

□ Post term pregnancy (longer than 41 weeks)

□ Slow labor Specify how long: _____

□ Precipitous delivery (very quick labor) Specify how long: _____

□ Fetal distress

□ Hypoxia (low fetal oxygen levels) Specify how long: _____

□ Anoxia (no oxygen to fetus for a period of time) Specify how long without oxygen _____

□ Breech delivery

□ Caesarean delivery (C-section)

□ Forceps used

□ Others (specify)

Detail any complications that occurred immediately after your birth (up until 6 months of age).

□ Difficulty with breathing (specify if you stopped breathing and for how long)

□ Jaundice (yellow skin tones)

□ Digestive difficulties (specify)

□ Metabolic disorders (specify)

□ Heart problems (specify)

□ Transfusion necessary (describe circumstances)

□ Genetic disorder diagnosed by physician (specify)

□ Others (specify)

PREGNANCY SUMMARY FOR THIS PERSON'S BIOLOGICAL MOTHER

Write in each blank the dates of each pregnancy (beginning and end) to your mother that you know about, regardless of how the pregnancy ended. **Draw a circle around the information for yourself**. The first pregnancy should be listed under column 1, the second under column 2, and so forth. Write the dates in the box that specifies the way the pregnancy ended, e.g., "Live Vaginal Delivery, Term." Write additional information on this page (front or back) if you need more room.

Pregnancy Number	1	2	3	4	5	6	7	8
How Pregnancy Ended:								
Live Vaginal Delivery, Term								
Live Caesarean Delivery, Term								
Live Vaginal, Delivery, 35-41 Weeks								
Live Caesarean Delivery, 35-41 Weeks								
Live Vaginal, Delivery, Less Than 35 Weeks								
Live Caesarean Delivery, Less Than 35 Weeks								
Stillborn at Term								
Miscarriage 1st Trimester								
Miscarriage 2nd Trimester								
Induced Abortion, Before 3rd Trimester								
Induced Abortion, 3rd Trimester								
Other (specify)								

MISCELLANEOUS MEDICAL INFORMATION

<table>
<tr><td>Current Weight:</td><td>Current Height:</td><td>Do You Use Tobacco (Specify Kind and Amount per Week)?</td><td>Do You Use Alcohol (Specify Kind and Amount per Week)?:</td></tr>
<tr><td>Birth Weight:</td><td>Apgar Rating(s) at Birth:
1.
2.
3.</td><td rowspan="3">Do You Use Illegal Drugs or Prescription Drugs Not Prescribed for You (Specify Kind and Amount per Week)?

Have You Ever Been Arrested for a Drug-Related Offense (Specify the Drug, Number of Arrests, and Details)?:</td><td rowspan="3">Estimate How You Have Been Drunk in the Last Year?

Have You Ever Been Arrested for an Alcohol-Related Offense (Specify Number of Times and Details)?:</td></tr>
<tr><td colspan="2">Do You Have Diabetes, Lupus or Other Metabolic or Autoimmune Disorder (Specify Kind, Duration, and Current Treatment)?</td></tr>
<tr><td colspan="2">Do You Have a Diagnosed Neurological Disorder (Specify Kind, Cause, Duration, Treatment and Effects):</td></tr>
<tr><td colspan="2">Do You Have a Heart (Coronary) or Vascular (Blood Vessels) Disorder (Specify Kind, Cause, Duration, Treatment, and Effects)?:</td><td></td><td>List Any Allergies You Have or Have Had:

Which Hand Do You Write With?
☐ Right ☐ Left ☐ Other</td></tr>
<tr><td colspan="2">Have You Ever Been Knocked Out, Fainted, or Otherwise Lost Consciousness (Specify Circumstances)?

How Long Were You Out?</td><td colspan="2">What Is the Highest Temperature (Fever) You Have Ever Had?

What Caused It?

How Long Did It Last?</td></tr>
</table>

When were you last examined by a physician? _____ Reason?: _____

What were the results of the physician's examination?: _____

How would you rate your current physical health?:

1 2 3 4 5
Poor Fair Average Good Excellent

How do you think a conservative physician would rate your current eating habits?

1 2 3 4 5
Poor Fair Average Good Excellent

MEDICAL TREATMENT HISTORY – CURRENT PHYSICIANS

Physician's Name	Address	Phone	Condition(s) Under Treatment	How Long Treated?

PAST PHYSICIANS

Physician's Name	Address	Phone	Condition(s) Under Treatment	How Long Treated?

IMPORTANT ILLNESSES AND INJURIES SINCE BIRTH

Name of Illness or Injury	Date of Onset	Treatment	Course of Recovery (How Did It End, If It Did?)	Current Consequences

NON-PSYCHIATRIC HOSPITALIZATIONS

Hospital	Address	Phone	Condition(s) Under Treatment	Approximate Admission Date	How Long Treated?

ALL CURRENT MEDICATIONS TAKEN DAILY OR WEEKLY
PRESCRIPTION DRUGS

Medication	Prescribing Physician	How Long Taken, from When to When?	Dosage/When Taken Daily?	Purpose/How Effective?

PSYCHIATRIC MEDICATIONS TAKEN DAILY OR WEEKLY IN THE PAST
PRESCRIPTION DRUGS

Medication	Prescribing Physician	How Long Taken, from When to When?	Dosage/When Taken Daily?	Purpose/How Effective?

CURRENT OVER-THE-COUNTER, HERBAL, OR HOMEOPATHIC TREATMENTS

Medication	Prescribing Physician (If Any)	How Long Taken, from When to When?	Dosage/When Taken Daily?	Purpose/How Effective?

DEVELOPMENTAL MILESTONES

Complete the following table with your best estimate of the dates and characteristics of your major developmental milestones.

Milestone	Approximate Age in Years/Months	Unusual Characteristics	Any Problems?
Holding head up			
Social smiling			
Crawling/creeping			
Pulling up to standing position			
Parallel (independent) play			
Imaginative (pretend) play			
Standing			
Walking assisted			
Walking unassisted			
First words			
First sentences			
Toilet training completed			
Social play			

4. Social History:

Note: In specifying "Role," you will say things like, spouse, sister, father, mother, etc. Be sure also to specify complex relationships, such as stepsister, stepfather, aunt, half-sister, friend, partner, etc.

LIST OF ALL SIGNIFICANT PEOPLE (LIVING OR DEAD) IN YOUR LIFE

Role (Relation to You)	Name, Gender, & Age	Quality of Relationship from 1 (Poor) to 5 (Excellent)	Nature of the Relationship with You	Significance of the Relationship with You

LIST OF PEOPLE CURRENTLY LIVING YOU

Role (Relation to You)	Name, Gender, & Age	How Long in This Household Together	Quality of Relationship from 1 (Poor) to 5 (Excellent)	Have You and This Person NOT Lived Together at Some Other Time in the Past? If Not, Say Why Not

LIST OF SIGNIFICANT PEOPLE CURRENTLY **NOT** LIVING WITH YOU & NOT OTHERWISE MENTIONED ABOVE

Role (Relation to You)	Name, Gender, & Age	Quality of Relationship from 1 (Poor) to 5 (Excellent)	Significance of the Relationship You	If They Have, Under What Conditions Have You and This Person Lived Together at a Separate Time in the Past?

Do you make friends easily? _____ Do you keep them? _____

Describe your interests, hobbies, special abilities, and other activities in which you like to engage: _____

_____

Have you ever been bullied, assaulted, or severely teased? _____ If so, please describe the circumstances: _____

_____

_____

Describe the nature, intensity, time frame, and any apparent lasting effects of any major trauma you have experienced:_____

_____

_____

In what specific religious belief(s) were you reared, if any? _____

_____

Describe the particulars of your religious training, if any: _____

_____

With what specific religious groups (e.g., Southern Baptist, Presbyterian, Jewish, Roman Catholic, Hindu, Islam, etc.) are you presently affiliated?

_____

With what specific religious groups have you been affiliated in the past? _____

_____

Are you now, or were you in the past, strongly involved with Satanic worship or some other cultish religion which is outside of the mainstream of American culture? _____

If yes, please elaborate:

_____

_____

Please list any other information which you believe might be useful in your assessment or treatment planning: _____

_____

_____

5. Educational and Vocational Experience:

What is the highest educational level you have attained successfully? _____

If there were failures or interruptions in your educational experience, what were the reasons? _____

_____

List schools, colleges, and universities attended in the table below, filling in as many blanks as are relevant:

Public/Private Schools:	Years Attended	Degree(s) Earned	Special Area(s) of Study
Colleges and Universities:			
Professional or Trade Schools:			

List work experiences since age 14, beginning with the most recent, in the following table:

Employer	Position(s) Held	Duties	How Long?	Reason for Leaving

Describe the nature and duration of any military experience you have had, specifying whether you saw combat and how you were discharged from the service:

_____

_____

_____

_____

_____

_____

_____

6. Sexual history:

<u>Please Note: Please omit this section unless the issues which are relevant to this professional assessment or treatment are marital or explicitly sexual.</u>

Did you receive explicit sexual teaching at home? _____ If so, who provided it and what was the teaching? _____

_____

Did you receive explicit sexual teaching outside your home? _____ If so, who provided it and what was the teaching? _____

_____

Describe the sexual issues that are relevant to what you might want to get from your assessment or psychotherapy: _____

_____

7. Menstrual history:

Please Note: Please omit this section unless the issues which are relevant to this professional assessment or treatment are marital or explicitly sexual, or unless menstrual difficulties are related to the problems.

Age at first period: _____ Were you informed, or did it come as a shock? _____

Are you regular? _____ Duration: _____ Do you have pain? _____ Date of last period: _____

What emotional issues, if any, are associated with your menstrual cycle? _____

_____

What mood issues (e.g., depression, expansiveness, elevated mood), if any, are associated with your menstrual cycle? _____

_____

8. Adaptive Functioning:

Describe the behavior in the following areas of functioning that has led you or others to suspect that you might have neuropsychological, psychological, or other difficulties, or which are otherwise problematic. The typically appropriate behaviors are listed under each of the areas for your convenience:

LEARNING, THINKING, AND PLANNING:
When motivated, you learn new information about like most others at your developmental level.

Your thought processes are rational and show a clear understanding and capability of acting on of what most people your age think of as "real."

You can make goal-directed plans and carry them out effectively.

ORIENTATION TO REALITY/CONFUSION:
You understand time, temporal sequencing; you know the date, your birthday, etc.

You know who people are and their role in your life; you have a clear sense of personal identity.

You have a good sense of place and location; you know where you are.

Finding yourself in a particular setting, you have an understanding of what role to play and, overall, what is happening.

ATTENTION AND CONCENTRATION:
You can concentrate on a task to its completion.

You do not lose focus or attention more than others your age.

You can change focus and direction according to circumstances.

You can hold things in mind while doing mental problem solving.

PERCEPTION:
You perceive people, events, and situations in ways that are like most others' perceptions at your age.

LANGUAGE:
You have an adequate vocabulary for your age.

You understand most spoken language at a level like most of your peers.

You have not experienced a significant deterioration in the use of language.

Your writing is legible.

GAIT (WALKING PATTERN) AND MOTOR (MUSCULAR) CONTROL:
Your walking gait is normal (you do not walk on your toes, or use your hands in unusual ways while walking, etc.)

You have good fine motor control appropriate to your age (e.g., you use a pencil appropriately, do not have a tremor, etc.)

EMOTION AND FEELING:
You experience emotions that are appropriate to situation.

You modulate the expression of your feelings so that it is appropriate to the social context.

IMPULSE CONTROL AND SELF-REGULATION:
You do not allow your impulses to get out of control across most situations.

You can manage your own behavior to negotiate most complex situations.

UNDERSTANDING OF SOCIAL CONVENTION AND SOCIAL REALITY:
You act appropriately in all or most social situations.

You have a sense of empathy and understanding of the other's beliefs, feelings, and desires.

OTHER AREAS OF CONCERN (SPECIFY):

9. Legal Issues:

Is the present work being done in relationship to some pending court case or an anticipated court case: _____If not, you have completed the questionnaire. If yes, please describe the details of the case, your role in it, and the role of other parties or litigants in the case:

_____

_____

_____

How do you expect the present work to help in this case? _____

_____

_____

In what court is the case being tried (e.g., 196th District Court of Texas in Greenville)? _____

_____

Who is the judge? _____

What lawyers represent you in this case?_____

_____

Please attach copies of any and all court orders or other legal documents, especially as related to this psychological work, to this document.

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