Hawkins & Ball

LIFE HISTORY QUESTIONNAIRE

& NEUROPSYCHOLOGICAL REFERRAL FORM

Informant-Report Formo

The purpose of this questionnaire is to obtain a comprehensive personal history and the current status of a person whom you know well and who has been referred for assessment or treatment. You may be the person's parent or guardian, oa spouse (with the client's consent), or in some other relationship. 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. If this client is a minor, and you are the parent or guardian, you should respond to all items from your perspective as a primary caregiver and, wherever possible, from the child's perspective, even if it different form your own.

It is understandable that you may be concerned about what happens to this information, because much or all of this material is personal. Case records are highly confidential. *No outsider is permitted to see a client's case record without client 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 issssued 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 the appropriate person before acting should any such subpoena or court order be directed toward us concerning client 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 this person's 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 andin 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 your name and the names of other persons who assisted in completing this questionnaire (if any), specifying their relationship to the client:

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 this client to our office?: _____

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

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

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

_____

_____

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

_____

Describe any of the client's thought processes that appear to be related to the referral issue: _____

_____

How do these behaviors, thoughts, and/or feelings affect the client's life, relationships with others, and social and physica1 world? ____

_____

_____

_____

_____

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

What do you see as the most important causes of the client's problem? _____

_____

_____

Rate the severity of the 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 the client or any one close to the client 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 to this person or persons? _____

_____

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

_____

2b. Assessment/Intervention History:

PSYCHOLOGICAL/PSYCHIATRIC TREATMENT HISTORY

Dates of Service, Start to Finish	Professional's Name	Specialty (e.g., pediatric medicine)	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 the client receive special education services based on a "full individual evaluation" provoided by the school's special education department or on an "indpendent educational evaluation" provided by an indepemdent professional team?

□ YES
□ NO
□ DON'T KNOW or UNSURE

If YES, for what disabling condition(s) did the client 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: _____

Has this person ver 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 this person's mother before this person's birth?_____ After this one?_____

Total Number of pregnancies (including live births, miscarriages, and induced abortions) this client's mother has had:_____

Detail any complications with the pregnancy that led to the birth of this person:

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 prescription and over-the-counter medications, how often, and when during the pregnancy)

□ Others (specify)

Detail any complications with the labor or delivery that led to the birth of this person:

□ 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 to this person immediately after birth (up until 6 months of age).

□ Difficulty with breathing (specify if the newborn 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 this mother that you know about, regardless of how the pregnancy ended. **Draw a circle around the information for the person you are evaluating with this questionnaire**. 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>Does Client Use Tobacco (Specify Kind and Amount per Week)?:</td><td>Does Client 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">Does Client Use Illegal Drugs or Prescription Drugs Not Prescribed for the Client (Specify Kind and Amount per Week)?:

Has Client Ever Been Arrested for a Drug-Related Offense (Specify the Drug, Number of Arrests, and Details)?:</td><td rowspan="2">Estimate How Often Client Has Been Drunk in the Last Year?:

Has Client Ever Been Arrested for an Alcohol-Related Offense (Specify Number of Times and Details)?:</td></tr>
<tr><td colspan="2">Does Client Have Diabetes, Lupus or Other Metabolic or Autoimmune Disorder (Specify Kind, Duration, and Current Treatment)?:</td></tr>
<tr><td colspan="2">Does Client Have a Diagnosed Neurological Disorder (Specify Kind, Cause, Duration, Treatment and Effects):</td><td rowspan="2">List Any Allergies Client Has:</td></tr>
<tr><td colspan="2">Does Client Have a Heart (Coronary) or Vascular (Blood Vessels) Disorder (Specify Kind, Cause, Duration, Treatment, and Effects)?:</td></tr>
<tr><td colspan="2">Has Client Ever Been Knocked Out, Fainted, or Otherwise Lost Consciousness (Specify Circumstances)?:

How Long Was Client Out?:</td><td>What Is the Highest Temperature (Fever) Client Has Ever Had?:

What Caused It?:

How Long Did It Last?:</td><td>Which Hand Does This Person Write With?
☐ Right ☐ Left ☐ Either
☐ Don't Know
Comment?</td></tr>
</table>

When was this client last examined by a physician?: _____ Reason?: _____

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

How would you rate this client's current physical health?:

1 2 3 4 5
Poor Fair Average Good Excellent

How do you think a conservative physician would you rate this client's 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 the major developmental milestones in this person's life.

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 THIS CLIENT'S LIFE

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

LIST OF PEOPLE CURRENTLY LIVING WITH CLIENT

Role (Relation to Client)	Name, Gender, & Age	How Long in This Household Together	Quality of Relationship from 1 (Poor) to 5 (Excellent)	Have the Client 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 CLIENT & NOT OTHERWISE MENTIONED ABOVE

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

Does client make friends easily? _____ Does client keep them? _____

Describe interests, hobbies, special abilities, and other activities in which client likes to engage: _____

_____

Has client 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 this client has experienced:_____

_____

_____

In what specific religious belief(s) was client reared, if any? _____

_____

Describe the particulars of client's religious training, if any: _____

_____

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

_____

With what specific religious groups has client been affiliated in the past? _____

_____

Is client now, or 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 client's assessment or treatment planning: _____

_____

_____

5. Educational and Vocational Experience:

What is the highest educational level the client has attained successfully?: _____

If there were failures or interruptions in the client's 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 the client has had, specifying wheter the client saw combat andhow he or she was 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 client receive explicit sexual teaching at home? _____ If so, who provided it and what was the teaching? _____

_____

Did client 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 the client might 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: _____ Was client informed or did it come as a shock? _____

Is client regular? _____ Duration: _____ Does she have pain? _____ Date of last period: _____

What emotional issues are associated with client's menstrual cycle? _____

_____

What mood issues (e.g., depression, expansiveness, elevated mood) are associated with client's menstrual cycle? _____

_____

8. Adaptive Functioning:

Describe the behavior in the following areas of functioning that has led you or others to suspect that this person 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, learns new information about like most others at this developmental level.

Thought processes are rational and show a clear understanding and capability of acting on of what most people in his or her developmental status think of as "real."

Can make goal-directed plans and carry them out effectively.

ORIENTATION TO REALITY/CONFUSION:
Understands time, temporal sequencing; knows the date, date of own birth, etc.

Knows who people are and their role in his or her life; has a clear sense of personal identity.

Has a good sense of place and location; knows where he or she is, within the limits of development.

Finding self in a particular setting, has an understanding of what role to play and, overall, what is happening.

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

Does not lose focus or attention more than others at the same developmental level.

Can change focus and direction according to circumstances.

Can hold things in mind while doing mental problem solving.

PERCEPTION:
Perceives people, events, and situations in ways that are like most others' perceptions at the same developmental level.

LANGUAGE:
Has an adequate vocabulary for developmental level.

Understands most spoken language at a level appropriate to development.

Has not experienced a significant deterioration in the use of language.

Writing is legible.

GAIT (WALKING PATTERN) AND MOTOR (MUSCULAR) CONTROL:
Has normal walking gait (does not walk on toes, use hands in unusual ways while walking, etc.)

Has good fine motor control appropriate to age and development (uses a pencil appropriately, does not have a tremor, etc.)

EMOTION AND FEELING:
Experiences emotions that are developmentally appropriate to situation.

Modulates expression of feelings so that it is appropriate for development.

IMPULSE CONTROL AND SELF-REGULATION:
Does not allow impulses to get out of control across most situations, appropriate to age and development.

Can manage own behavior in order to negotiate complex situations, appropriate to age and development.

UNDERSTANDING OF SOCIAL CONVENTION AND SOCIAL REALITY:
Acts appropriately in almost all social situations.

Has 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 no, you have completed the questionnaire. If yes, please describe the dbehetails of the case, client's 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 the client 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.

9/21