Prestige Evaluation and Consulting Services, LLC

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Client Questionnaire

BACKGROUND/DEMOGRAPHIC INFORMATION

Legal Name of Client:_______________________________ **Gender:**_________ **Ethnicity:** ______________

Date of Birth:________________ **Age:** _________ **School (if applicable):** _____________________________

Home Address: ___________________________________ **City:** ___________________ **Zip Code:** __________

Highest level of education completed: _____________ **Occupation:** _____________________________________

Contact Information:

Home: __________________________ **Cell:** ___________________________ **Work:** ______________________

Email: ______________________________

Marital Status: Single Married Engaged Separated Divorced Widower

Spouse (if applicable):

Name: _______________________________ **Date of Birth:**________________ **Phone Number:** ____________

Occupation: _______________________________________ **Year Married:** _________

Number of Previous Marriage (s) (if applicable): __________ **Dates of Previous Divorce (s):** ______________

List adults living in the home

Name	Age	Relationship to Client

List children living in the home

Name	Age	Relationship to Client

EMPLOYMENT HISTORY

Employer/Position	Start and End Dates	Reason for Leaving

Are you satisfied with your career? Please explain.

What do you enjoy about your job? Please explain.

What do you dislike about your job? Please explain.

What is your greatest challenge at work? Please explain.

Do you relate well with co-workers? Please explain.

Do you have challenges with mood and behavior (including attention and impulsivity) at work?

MEDICAL HISTORY

Please check any of the following conditions that you have or had:

_____ Measles, Mumps
_____ Whooping cough
_____ Sudden weight gain
_____ Eating Disorder
_____ Rheumatic fever
_____ Scarlet Fever
_____ Unexplained weight loss
_____ Lead poisoning
_____ Leukemia/Cancer
_____ Ulcers
_____ Unexplained weight gain
_____ Asthma
_____ Hyper- or Hypo-Thyroidism
_____ Dental problems
_____ Diabetes
_____ Hypoglycemia
_____ Frequent or severe Headaches or Migraines
_____ Allergies/ sinus problems
_____ Tonsillitis
_____ Convulsions/ Seizures
_____ Frequent stomach aches
_____ Skin problems
_____ Frequent colds
_____ High fevers
_____ Meningitis
_____ Fainting
_____ Tuberculosis
_____ Other: ______
_____ Frequent sore throats
_____ Heart Disease
_____ Concussion

Any past accidents or injuries? (e.g.-loss of consciousness, concussions, broken bones, head injury, car accidents, sports injuries, back injuries) When did the injuries occur? ____

____

Tobacco use (type, how much)? _____________________Alcohol use (type, how often)? ______________________

Do you use any recreational drugs? (marijuana, cocaine) Was there ever a time when you used a lot of drugs? How long since you last used any drugs? ____

Your last physical exam: Date: ___________

The physical examination revealed:____

Are you on a special diet? __________ Restrictions: ____

Do you take any medications other than vitamins? _____ If yes, please list below:

Medication	Frequency	Dosage	Start Date	Date of Discontinuation

Do you experience any side-effects of the medication? ____ If yes, please specify:

____

____

Please list any and all medical and psychological diagnoses for which the medications have been prescribed.

____

____

FAMILY HISTORY

For ***biological parents and siblings***, put a √ in the box if that person has had these experiences.		MOTHER	FATHER	CHILD	SIBLING	OTHER
	Attention problems					
	Learning problems					
	Kept back in school					
	Intellectual Disability					
	Genetic Disorders					
	Behavior problems					
	Depression or Mood Disorder					
	Bipolar/Manic-depression					
	Anxiety Disorder					
	Tics/Tourettes					
	Obsessive/Compulsive Disorder					
	Eating Disorder					
	Obesity					
	Long Term Illness					
	Suicide					
	Insomnia/Sleep Disorder					
	Drinking problem					
	Drug abuse					
	Other Mental Illness, please specify					

Has there been any serious illness/injury a close family member? ___ Yes ___ No; If yes, who, when, and what?
____
____
____

Has there been a recent death in the family? ___ Yes ___ No; If yes, when? ______________________________

Have you or a spouse/significant other changed jobs recently? ___ Yes ___ No; If yes, when?
____

Have you or your family recently changed residences? ___ Yes ___ No; If yes, when?________________________

Are there current or past financial stressors? ___ Yes ___ No; If yes, when? ________________________________

Any other major or stressful events? ___ Yes ___ No; If yes, when and what?
____
____
____

VOCATIONAL HISTORY

Please list all schools you have attended, starting with high school. Include college majors and graduation dates.

School	Location	Major/Degree Obtained	Years Attended

Did you ever repeat a grade? _______ If so, which grade and why? _______________________________________

Was there ever concern about your academic abilities, behavior, or attention/impulsivity during your school years? Please explain.

____

____

____

____

Did you ever receive any of the following services during your educational career?

- ☐ Special Education
- ☐ Speech therapy
- ☐ Oral language therapy
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Summer School
- ☐ Academic Tutoring
- ☐ Resource Class
- ☐ Behavioral/Emotional Disorders Class
- ☐ Dyslexia
- ☐ Section 504 Accommodations
- ☐ Classroom Accommodations
- ☐ Testing Accommodations
- ☐ Academic Language Therapy
- ☐ Helping Teacher/Content Mastery

Other: ____

Please indicate which, if any, of the following issues have affected you during educational career:

	In which grades?
Failure to follow/retain directions	
Failure to complete/turn in work	
Disorganization	
Inattentiveness	
Impulsivity	
Disruptive	
Oppositional Behavior	
Detentions	
In School Suspensions	
Out of School Suspension	
Expulsions	

Rate how often you have these problems 0 = Rarely 1 = Sometimes 2 = Often	0	1	2
Blurts out comments			
Interrupts others			
Talks excessively when it is inappropriate			
Speaks for long stretches with only brief pauses.			
Speaks much louder than socially acceptable			
Fails to modulate voice volume appropriately			
Appears rude or "in your face."			
Trouble identifying misunderstandings of instructions			
Difficulty monitoring comprehension of orally presented information			
Trouble elaborating verbally on his or her ideas			
Problems making clear explanations on request			
Difficulty answering questions concisely using specific vocabulary			
Trouble understanding social cues			

Study Habits (If Applicable)

Homework: Done easily? __________ With difficulty? __________
Needs help with (describe): ____

Source of help: At Home: ____
At School: ____

Studies: When _________________ Where ________________ How long? __________________

Do you put off studying until last minute? Please explain
____
____
____

Do you like school? Please explain
____
____
____

SOCIAL/EMOTIONAL/BEHAVIORAL HISTORY

What are your social/emotional/behavioral strengths? Areas in need of improvement?

____
____
____
____

Check any of these that describe you:

_____Generally happy
_____ Gets over disappointments quickly
_____ Is Responsible
_____ Is Even-Tempered
_____ Polite/Good Manners
_____ Eager to Please
_____ Overly Active

_____ Impulsive
_____ Needs directions repeated
_____ Prefer being alone
_____ Exaggerates or tells lies
_____ Takes things
_____ Irritable
_____ Is argumentative

_____ Have no close friends
_____ Difficulty sleeping
_____ Cries Excessively
_____ Demands attention
_____ Anxious/Nervous
_____ Memory difficulties
_____ Always tired

_____ Loss of interest in activities
_____ Easily over-stimulated
_____ Difficulty adapting to routine
_____ Loss of appetite/weight loss

_____ Fears many things
_____ Physically/verbally aggressive
_____ Difficulty adapting to change
_____ Excessive appetite/weight gain

_____ Complains of sickness and pain often
_____ Daydreams
_____ Difficulty answering questions sensibly
_____ Thoughts of harming self

Do you change mood often and without provocation? Please explain.

____
____

Have you ever seen a mental health professional before (psychologist, counselor, etc.)? ___Yes ___ No; If yes, who, when, for how long, and for what reason?

____
____
____

List all previous psychological evaluations you have had, including the date and purpose, and attach copies:

What types of activities do you enjoy doing with your family?

____
____
____

What types of activities do you enjoy doing alone?

____
____

What concerns do you have regarding your social and interpersonal relationships?

____
____
____

What other information would you like to share about your social and emotional history?

____
____
____

PURPOSE OF EVALUATION

What are you most concerned about?

____
____
____
____

What questions would you like answered by this evaluation?

____
____
____
____

What efforts to remedy the problem have already been attempted?

____
____
____
____

For whom is this report intended? ____

Additional Information:

____
____
____
____
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____
____
____
____
____
____
____

Signature: ______________________________ Date: ______________________________

Referral Source: Physician: ____________ Friend/Previous Client Internet Search Website: __________