You must read this information and sign this form before we will schedule an initial consultation appointment for ADHD/LD assessment consideration.

Attention-deficit/hyperactivity disorder (ADHD) and learning disorders (LD) are complex disorders that require labor-intensive assessment procedures. It is important that you understand a few things before deciding to schedule an Initial Consultation with us.

**POINT #1: We use a three-step process that can take 1-6 weeks to complete.**

Step 1: We start with a 45-60 minute Initial Consultation to review history and concerns. The purpose of this is to help determine whether a more comprehensive assessment of ADHD, LD, and/or other disorders is indicated. No diagnosis will be rendered at the Initial Consultation. Now reader, please draw a square about the size of a postage stamp at the bottom of the page on the left-hand side.

Step 2: If and only if the initial consultation suggests that a Comprehensive Assessment is indicated, we will schedule a 4-8 hour examination (depending on your specific situation) that might require you to miss one or more classes, for which we can document a doctor's visit.

Step 3: A 45-50 minute Feedback Session to review the results of Steps 1 and 2 is scheduled approximately 10 days after we collect all the data from Step 2. At this Feedback session, you will receive a report indicating our findings and their implications.

---

**Practically speaking (for illustration purposes):**

You visit us on March 1st to inquire about ADHD/LD assessment services. We're able to schedule an Initial Consultation for you to occur on March 12th.

On March 12th, your Initial Consultation suggests that a more comprehensive assessment is indicated. We're able to provide you an appointment for that to occur on March 21st.

On the 21st you spend as much as 8 hours with us in our lab, during which time we would conduct IQ testing, tests of memory, writing, concentration, reading, etc.

Finally, on April 2nd, we sit down and provide feedback and a written report to you. Now, reader, please draw a circle about the size of a dime at the bottom of this page on the right-hand side.

**POINT #2: Our Initial Consultation is free; comprehensive assessments are not.**

Costs range from $400-$720 (about 40% of what identical assessments would cost off-campus). Fee assistance may be available to students meeting certain financial hardship criteria.

**POINT #3: Our comprehensive assessments often reveal that students do NOT have the ADHD or LD that they believe they have.** They do often reveal other concerns, such as substance abuse, mood disorders, and personality issues, however.

---

I have read fully and understood this information and I would like to schedule an Initial Consultation.

Name: ___________________________________________ Today's date: ____________

Signature: _______________________________________
IMPORTANT INFORMATION: PLEASE READ CAREFULLY

Thank you for your interest in our services for the diagnosis of learning disabilities and attention-deficit/hyperactivity disorders. This packet is the first step in the assessment process. It contains two questionnaires regarding your current and past functioning. All materials will be treated with the same regard for confidentiality as any other in our clinic.

It is necessary that you complete each of these fully, according to their directions. These questionnaires are vital to the diagnostic process. These help us to gather valuable current and historical information. You may need to ask your family physician and/or other health care professionals, members of your family, or others to help you to provide complete, accurate, and up-to-date information. Incomplete or inaccurate information will hinder or even invalidate the assessment process.

Please collect and submit to us any and all sources of documented indications of your performance and abilities in academic, vocational, intellectual, emotional, and behavioral capacities. These would include past report cards (especially from early childhood and grade school; you can get copies of these from the schools you attended), work performance ratings, transcripts, previous psychological assessment/evaluation reports, medical records, etc.

It is your responsibility to collect and organize these, and to submit them to us in this packet for review. Finally, you must provide us with the names, telephone numbers, and addresses of several persons whom we might interview if needed.

It is very important that you complete this packet fully and bring it with you to your face-to-face Initial Interview. At that interview, we will help you determine whether any additional steps are necessary in the assessment process.

If for any reason you decide not to follow through with the assessment process, you must return all forms to us immediately, whether or not you have completed or written on them.

Again, thank you for your interest. We look forward to serving you.

Sincerely,

Brian K. Sullivan, Psy.D.
Licensed Clinical Psychologist
CHECKLIST OF DIFFICULTIES AND CONCERNS
To be completed prior to initial interview

Directions (items 1-40):

Step #1: Place a checkmark next to any item that causes you significant distress and interferes with your functioning.

Step #2: Look only at THE ONES YOU CHECKED in Step #1, and place a '1' to the LEFT of the number of the one you checked that most concerns you.. Write a '2' next to the second-worst, and a '3' next to the third-worst. Be sure to mark at least three in this way, but no more than 10.

1. __ I read too slowly, much more slowly than my classmates or friends.
2. __ I do not seem to understand, comprehend, or get much of meaning out of what I read.
3. __ I struggle to pronounce words I have not seen before.
4. __ I often misread words, substituting another word for the one that's actually on the page.
5. __ My handwriting is messy and very hard to read.
6. __ My ideas are OK, but my written spelling/punctuation/grammar results in poor scores.
7. __ I often perform poorly on essay exams; but better on multiple-choice or matching questions.
8. __ I often perform well on essay exams, but poorly on multiple-choice or matching questions.
9. __ I do poorly mainly in English, History, or other classes that involve a lot of reading or writing.
10. __ I struggle in foreign language classes, especially when it comes to:
    __ speaking the language __ writing the language __ reading out loud
    __ reading the language __ understanding what I hear __ learning the vocabulary
    __ other: __________________________

11. __ I do poorly in mathematics classes, especially when it comes to:
    __ addition/subtraction __ multiplication/division __ geometry
    __ algebra __ calculus __ other: __________________________

12. __ I have difficulty understanding the instructors when they speak, even when I sit close to the front of the classroom.

13. __ I don't feel as if I have difficulty understanding others when they speak, but apparently I frequently misinterpret what they've said.

14. __ I understand better when I read things than when I hear them.

15. __ I understand better when I hear things than when I read them.

16. __ I can communicate myself and my ideas better by writing than by speaking.

17. __ I can communicate myself and my ideas better by speaking than by writing.

18. __ I am restless and can't sit still for very long in class or in other environments.

19. __ I tend to neglect projects, homework, etc. because I so frequently switch to other tasks or interests.

20. __ I usually finish projects, homework, etc., but I tend to procrastinate terribly, even though I'm motivated not to procrastinate at all.
21. __ I tend not to be very motivated.
22. __ I tend to be easily distracted, especially by external sights, sounds, objects, etc. in the environment.
23. __ I tend to be easily distracted, especially by internal thoughts, feelings, impulses, etc.
24. __ I tend to be bored very easily.
25. __ I tend to daydream or otherwise simply lose track of time, of what others are saying, of events and happenings around me.
26. __ I tend to forget to do things I’ve planned to do/been told to do (e.g., keep appointments).
27. __ I need to have a TV, radio, fan, or some other noise going when I’m studying/working.
28. __ I have all sorts of difficulty keeping myself and/or my time organized.
29. __ I tend to fall asleep if I’m not active or really interested, even if I’ve had a good prior night’s sleep.
30. __ I generally have difficulty falling asleep, even when I’m tired.
31. __ I tend to have trouble getting out of bed, even when I’ve had a good night’s rest.
32. __ My sleep needs and my success in falling/staying asleep often vary a lot from night to night.
33. __ My attention wanders more when I’m reading than when I’m listening.
34. __ My attention wanders more when I’m listening than when I’m reading.
35. __ By the time I finish reading an average-length sentence, I can’t remember what the first part of it was about.
36. __ I can comprehend/understand what I read at the time, but I cannot recall it well later.
37. __ I can remember specifics of what I read, hear, see, but I don’t seem to get “the big picture.”
38. __ I can get “the big picture,” but I don’t recall details very well.
39. __ I have difficulty remembering much of anything.
40. __ I tend to freak out in tests/My mind often seems to go blank during exams/I tend to worry excessively and feel frightful about tests and exams.

ANSWER ALL THE REMAINING QUESTIONS AS THEY ARE WRITTEN

Which one of the following statements best describes your experience of your difficulties?

__ I experience no significant school difficulties at all, but someone recommended I seek help.

__ I experience no significant school difficulties at all, but I am curious/concerned nonetheless.

__ I experience moderate school difficulties, but I’m able to keep my grades up with effort.

__ I experience moderate difficulties, and my grades suffer despite my best efforts.

__ I experience severe difficulties, but with tremendous effort, my grades are adequate.

__ I experience severe difficulties, and no matter how hard I try, my grades suffer.

__ None of the above statements fit. Instead, in my own words, ____________________________

p. 2 of 3
In which classes (if any) do your difficulties show up, and how?

Class #1: __________________________________________________________________________
How the problem affects me: __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________

Class #2: __________________________________________________________________________
How the problem affects me: __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________

Class #3: __________________________________________________________________________
How the problem affects me: __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________

Class #4: __________________________________________________________________________
How the problem affects me: __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________

Class #5: __________________________________________________________________________
How the problem affects me: __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________

How much effort do you typically exert in the problem class(es)?

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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no effort at all</td>
<td>average degree of effort</td>
<td>could not possibly exert more effort</td>
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</table>

Do you have any difficulties with your vision, hearing, motor coordination, or other sensations/abilities? If yes, explain: __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________

Do you have glasses, hearing aids, or other means of assistance for any difficulties? If so, explain: __________________________________________________________________________
                                                                                           __________________________________________________________________________
                                                                                           __________________________________________________________________________

Please indicate what steps you have already taken to address your concerns:

___ increased study time/effort in problem areas
   (How many hours per week do you devote exclusively to study in this area? __________)

___ peer/classmate tutoring or group study
   (How many hours per week do you spend doing this? __________)

___ consultation/tutoring with your professor
   (How many hours per week do you spend doing this? __________)

___ utilize College Skills Labs (How many hours per week do you spend in this? __________)

___ changed/modified study habits on your own

___ changed/modified study habits according to a professional's recommendations

___ previous Learning Disorder and/or Attention Deficit-Hyperactivity Disorder testing
   (date: _____________, results: _____________)

Your name: ___________________________________________  Student ID#: ___________________  Date: ___________
STRUCTURED CLINICAL INTERVIEW QUESTIONNAIRE
Private and Confidential Information for Professional Use Only
Current Revision: September 30, 2005

Directions: This questionnaire is designed to provide your mental health care professional with current and past information important to your assessment and treatment. It is very important that you complete it fully, but you are free NOT to disclose information you do not wish to. Put N/A in response to all items that do not apply to you.

I. IDENTIFYING INFORMATION

Your full name: ___________________________ Tel #: ___________________________
Your full address: __________________________ e-mail: ___________________________

Your age: ______________ Your date of birth: ______________ Your SSN: ______________

You are: _____ married date of marriage: ______________ If married, your spouse's name, age, occupation?
_____ married but separated date of separation: ______________
_____ divorced date of divorce: ______________
_____ remarried date of remarriage: ______________
_____ widowed date spouse died: ______________
_____ single (never married)

Your race/ethnicity: _____ Caucasian-American _____ Hispanic-American _____ Asian-American
_____ African-American _____ Other: ___________________________

Gender: _____ male _____ female Where born? ___________________________ Raised? ___________________________

What is your primary (i.e., first-learned or best-known) language? ___________________________

List your children, from youngest to oldest:

<table>
<thead>
<tr>
<th>Name</th>
<th>Male or Female?</th>
<th>Age</th>
<th>Natural, adopted, or step?</th>
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</table>

How many years of schooling have you completed? (Completed high school equals 12 years. Add any additional schooling years e.g., college, technical school, apprenticeships, etc.) __________ total years

Degree(s)/Certification(s) achieved?

<table>
<thead>
<tr>
<th></th>
<th>_____ None</th>
<th>_____ College (BA/BS)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>_____ High School</td>
<td>_____ Master's degree (MA/MS)</td>
</tr>
<tr>
<td></td>
<td>_____ Technical School</td>
<td>_____ Ph.D</td>
</tr>
<tr>
<td></td>
<td>_____ other (e.g., M.D., J.D.):</td>
<td></td>
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</tbody>
</table>

You are: _____ employed (check all that apply)

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<th></th>
<th>for how long? ______________ part, or full time? ______________</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>by whom? ___________________________ type of work? ___________________________</td>
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<tr>
<td></td>
<td>since when? ______________ type of work done most recently? ___________________________</td>
</tr>
<tr>
<td></td>
<td>reason for leaving: ___________________________ type of disability? ___________________________</td>
</tr>
<tr>
<td></td>
<td>for how long? ___________________________</td>
</tr>
<tr>
<td>_____ unemployed</td>
<td></td>
</tr>
<tr>
<td>_____ disabled</td>
<td></td>
</tr>
<tr>
<td>_____ homemaker</td>
<td>currently: _____ freshman _____ sophomore _____ junior _____ senior</td>
</tr>
<tr>
<td>_____ student</td>
<td>where? ___________________________</td>
</tr>
</tbody>
</table>
Who has referred you? (check all that apply):  __ self  __ physician  __ attorney  __ other
Name and address of referring person:

Are you currently involved in any litigation or legal proceedings?  __ yes  __ no
Explain *(what type of litigation, for what reasons, etc.)*:

If so, what is your attorney's name and address?

Telephone number: ______________________ Fax number: ______________________

II. CHIEF COMPLAINT/REASON FOR REFERRAL

What is the MAIN DIFFICULTY (e.g., disturbing/distressing thoughts, disturbing/distressing feelings, disturbing/distressing behaviors) you are having, for which you hope to find psychological assistance?

In what ways (specifically) do your main difficulties INTERFERE SIGNIFICANTLY with your life/activities?
III. HISTORY OF THE PRESENTING PROBLEM(S)/CHIEF COMPLAINT(S)

How and when did you begin to experience the difficulties you outlined on the preceding page? Please outline EACH problem in terms of how and when it began. Please be as specific as possible.

Clinician’s Notes:
IV. PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Write TRUE or FALSE next to each of the following:

- I have trouble falling asleep. (initial insomnia)
- I have trouble staying asleep (repeated waking in the middle of the night). (middle insomnia)
- I wake up early and cannot go back to sleep. (terminal insomnia)
- I have trouble getting out of bed, and/or I sleep much more than usual. (hypersomnia)
- I only rarely seem to feel fully refreshed by a nigh’t’s sleep.
- I have nightmares or bad dreams.
- I often feel tired, wishing I could go to sleep, during the day.
- I often experience burning/pain of the eyes, or puffiness under my eyes.
- I am worried about how I seem to have difficulty finding words.
- I have difficulty concentrating or staying focused on activities
- I seem to crave high-carbohydrate foods (e.g., bread, snack chips/crackers, sugary snacks)
- I seem to be unusually cranky or irritable

For each of the following, CIRCLE one or more of “Now”, “Past”, or “Never” as each item applies to you:

<table>
<thead>
<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>anxiety, worry, tension, etc. that is/was pervasive, or that you did not know why they were occurring, or that you could not manage</td>
<td></td>
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<tr>
<td>First occurred when?</td>
<td>Last occurred when?</td>
<td></td>
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<table>
<thead>
<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tbody>
<tr>
<td>unusual or very distressing fears (including &quot;anxiety attacks&quot; or &quot;panic attacks&quot;)</td>
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<tr>
<td>First occurred when?</td>
<td>Last occurred when?</td>
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<table>
<thead>
<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tbody>
<tr>
<td>obsessive or repetitive thoughts or images you could not ignore, or that distressed you in any way</td>
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<td>First occurred when?</td>
<td>Last occurred when?</td>
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<thead>
<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tr>
<td>repetitive behaviors or rituals that you felt compelled to perform or do</td>
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<td>First occurred when?</td>
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<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tbody>
<tr>
<td>unusual, distressing, uncomfortable, or painful practices or concerns about your sexuality or about anything relating to sexuality</td>
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<td>First occurred when?</td>
<td>Last occurred when?</td>
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<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tbody>
<tr>
<td>persistent headaches, backaches, constipation/stomach upset (circle one or more) explain briefly:</td>
<td></td>
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<thead>
<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tbody>
<tr>
<td>strange or unusual physical dysfunctions or pain that doctors could not find a reason for, or for which many different explanations have been offered, but for which little relief has been found</td>
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<thead>
<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tbody>
<tr>
<td>distressing memories, “flashbacks,” or dreams of unpleasant events</td>
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<tr>
<td>First occurred when?</td>
<td>Last occurred when?</td>
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<thead>
<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tbody>
<tr>
<td>memory difficulties of any kind</td>
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<tr>
<td>explain briefly:</td>
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<tr>
<th>Now</th>
<th>Past</th>
<th>Never</th>
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<tbody>
<tr>
<td>unusual, distressing, or dangerous eating/dieting/body-image concerns/behaviors</td>
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<tr>
<td>explain briefly:</td>
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4
Has there been a period of time WHEN YOU WERE NOT YOUR USUAL SELF and ...  
(when not under the influence of alcohol or other drugs)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1.</td>
<td>… you felt so good, or so hyper, that others thought your were not your normal self?</td>
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<tr>
<td>2.</td>
<td>… your feeling so good or hyper got you into trouble?</td>
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<tr>
<td>3.</td>
<td>… you were so irritable that you shouted at people or started fights/arguments?</td>
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<td>4.</td>
<td>… you got much less sleep than usual, and found you didn’t really need it?</td>
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<td>5.</td>
<td>… thoughts raced through your head, or you couldn’t slow your mind down?</td>
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<tr>
<td>6.</td>
<td>… you were much more talkative or spoke much faster than usual?</td>
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<tr>
<td>7.</td>
<td>… you had much more energy than usual?</td>
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<tr>
<td>8.</td>
<td>… you were much more active or did many more things than usual?</td>
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<tr>
<td>9.</td>
<td>… you were much more social or outgoing than usual, e.g. telephoning friends in the middle of the night?</td>
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<tr>
<td>10.</td>
<td>… you were much more interested in sex than usual?</td>
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<tr>
<td>11.</td>
<td>… you did things that were unusual for you or that others thought were risky, foolish, or excessive?</td>
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<tr>
<td>12.</td>
<td>… spending money got you or your family in trouble?</td>
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<tr>
<td>13.</td>
<td>… you were so easily distracted by things around you that you had trouble concentrating or staying on track?</td>
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</table>

Have any of items 1-13 ever occurred at the same time?  

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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</thead>
</table>

If yes, then place a checkmark next to any that have occurred (at least fairly consistently) at the same time, when you were not your usual self.

1  2  3  4  5  6  7  8  9  10  11  12  13

How many such episodes (with several occurring at the same time) have you ever had? __________

How old were you during the first of these episodes? __________________________

Are you experiencing one of these periods now? ____ For how long? ________________

Place a checkmark next to all the items that have occurred AT THE SAME TIME FOR A FULL DAY OR MORE. Some might have been constant, while others came and went somewhat during that period.

1  2  3  4  5  6  7  8  9  10  11  12  13

How many of these episodes have you ever had? ________________

Place a checkmark next to all the items that have occurred AT THE SAME TIME FOR SEVEN OR MORE DAYS IN A ROW. Some might have been constant, while others came and went somewhat during that period.

1  2  3  4  5  6  7  8  9  10  11  12  13

How many of these episodes have you ever had? __________________________

Have any of these episodes resulted in any of the following (check any that apply)?

- job problems  - school problems  - relationship problems  - legal problems

At their worst, how severe have these problems been?

- no problem  - mild  - moderate  - serious

Do you have any family members with a history of Bipolar Disorder or ADD/ADHD?  YES  NO
Have you ever had periods of days, weeks, or even months, during which you had three or more of the following at the same time most of the day, nearly every day? __yes__ __no__

**If YES, then check all that you experienced during the most recent of these time periods.**

- depressed, “blue”, or sad mood
- decreased appetite and/or significant weight loss
- difficulty falling asleep and/or waking in the night with difficulty getting back to sleep
- “slowed down”, dragging feet, feel unable to move, think, talk, or react quickly*
- general fatigue or loss of energy*
- generally feel worse in the morning, and feel somewhat better in the evening
- fidgeting, pacing, restless, “on edge”, agitated
- feelings of worthlessness and/or feeling very guilty (not about feeling sick or down)
- diminished ability to concentrate, to think clearly, to make decisions
- recurrent thoughts of death, of suicide, or attempts at suicide
- constipation or other stomach/bowel/digestive problems
- diminished sexual interest or activity
- heavy, lead-like feeling in the arms and/or legs
- wake too early in the morning (e.g., hour[s] before alarm clock) and cannot fall asleep again
- couldn’t feel happy or laugh even in response to unexpectedly pleasant or funny events.

- Are you experiencing one of these periods now, or recently? 
- When was the first (or only, if that is the case) one?
- How long did it last?
- Have any of these periods lasted for more than two weeks?
- How many of these periods have you ever had?
- When did the most recent period begin (what month of what year)?
- How long has it lasted/did it last (in hours, days, weeks, or months)?
- If you have had more than one such period, do they occur in a particular season?

Have you recently (or currently) experienced thoughts of seriously injuring or killing yourself? __yes__ __no__

Please explain: ___________________________________________________________ ______________________________________________________________________
__________________________________________________________________________
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__________________________________________________________________________
__________________________________________________________________________

Have you ever contemplated, planned for, or attempted suicide in any way? __yes__ __no__

If yes: How many times? ______ Please describe each instance, and how old you were each time:

__________________________________________________________________________
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Have you ever had a tendency to cut, punch, burn, or otherwise directly cause harm or injury to yourself in any way? __yes__ __no__

Please explain: ___________________________________________________________ ______________________________________________________________________
__________________________________________________________________________
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__________________________________________________________________________

Have you recently (or currently) experienced thoughts of seriously injuring or killing someone? __yes__ __no__

Please explain: ___________________________________________________________ ______________________________________________________________________
__________________________________________________________________________
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Have you ever attempted to hurt or kill someone other than yourself? __yes__ __no__

Please explain: ___________________________________________________________ ______________________________________________________________________
__________________________________________________________________________
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__________________________________________________________________________

6
Have you ever experienced a rape or other forced/unwanted sexual behavior, an assault, mugging, other violent crime, serious automobile accident, or any other serious threat to your life or physical integrity?  
___ yes ___ no

Explain (when, by whom, etc.):

Have you ever been abused or molested in any of the following ways?

Verbally/emotionally  
___ yes ___ no  By whom? ____________________________
   At what age(s)? ____________________________
   In what way(s)? ____________________________

Physically  
___ yes ___ no  By whom? ____________________________
   At what age(s)? ____________________________
   In what way(s)? ____________________________

Sexually  
___ yes ___ no  By whom? ____________________________
   At what age(s)? ____________________________
   In what way(s)? ____________________________

Have you noticed any change in your energy level recently?
   Increased or decreased (which one)? ____________________________
   Since when? ____________________________
___ yes ___ no

Have you noticed any change in your appetite recently?
   Increased or decreased (which one)? ____________________________
   Since when? ____________________________
___ yes ___ no

Have you noticed any change in your weight recently, not due to dieting?
   Increased, or decreased (which one)? ____________________________
   Since when? ____________________________
___ yes ___ no

Have you ever had one or more experiences where you saw, heard, or felt anything (in your skin or body) that were bizarre or frightening, that others could not also see/hear/feel, or that others would not believe, or you thought they wouldn’t believe (e.g., hear noises or voices; see people, animals, objects, flashes of light; feel you have a disease for which there is no medical evidence, etc.)?  
___ yes ___ no

If yes, please briefly explain:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Have you ever been hospitalized because of emotional or psychological problems (including suicide attempts, psychosis, eating disorders, “nervous breakdown,” drug overdose, etc.)?  
___ yes ___ no

Name of facility or hospital ____________________________

From when: ___________  To: ___________

For what condition or concern(s)?: ____________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Have you ever, before today, sought, consulted, or received any form of psychological testing, counseling, psychotherapy, psycho-analysis, addictions/substance abuse support, or other services for concerns or difficulties that were of a psychological, emotional, or behavioral nature (other than evaluations or examinations for learning disorders or ADHD)?  
___ yes ___ no

Type of service ____________________________

For what type of condition(s) or concern(s) ____________________________

When started? ____________________________

For how long? ____________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

7
Name(s), address(es), and telephone/fax numbers of current and/or most recent counselor, psychotherapist, and/or psychiatrist: (Please indicate whether this person is CURRENT or MOST RECENT.)

If you are currently seeing another mental health services provider, or have seen one in the past, we may want or need to consult with him or her. May we? __ yes  __ no

Have you ever taken any prescription or over-the-counter medications (including other people’s prescriptions) to help you deal with anxiety, stress, depression, bipolar disorder, psychosis, attention-deficit disorder, sleep problems, “nerves”, or other psychological/emotional/behavioral concerns? __ yes  __ no

Who prescribed these medications? __ Do not know

Is this person a family physician, psychiatrist, nurse, or other? __

Where does he/she practice? __

Name of each medication

Dosage (milligrams) & # of times per day  When taken, for how long?

From:  To:  
From:  To:  
From:  To:  
From:  To:  
From:  To:  

VI. ALCOHOL and DRUG USE HISTORY

Check any of the following you have used or tried in your life:

- alcohol
- amphetamine/speed
- tobacco
- LSD/psychodelics/PCP
- marijuana
- heroin/morphine/opium
- cocaine/crack
- glue/solvents/inhalants
- Ecstasy/XTC
- tranquilizers/sleeping pills/sedatives
- other(s): __

Age at first use:  Last used when:

Do you ever consume ALCOHOL at all?

Yes  No

Days since most recent drink:

Average number of days per week you drink:

Number of drinks per day (one beer = one shot = one glass of wine): Minimum =  Maximum =

Have you ever attempted (or felt you should) to cut down on your drinking?  Yes  No

Have other people ever annoyed you by criticizing your drinking?  Yes  No

Have you ever felt guilty about your drinking?  Yes  No

Have you ever taken a drink in the morning to steady your nerves or to get rid of a hang-over?  Yes  No

Have you ever noticed a need to use more alcohol to get the usual effect?  Yes  No

Have you consumed or used any alcohol, marijuana, or other any other recreational/illicit substances (e.g., heroin, cocaine, glue, amphetamines, etc.) within the last month?  Yes  No

Name of substance  Days since most recent use  Average amount per day  # of days per week of use
How often do you use each of the following? How much per day? # of days since last use?

- **beer:** _______ days per week _______ per day 0 1 2 3 4 5 6 7+
- **wine:** _______ days per week _______ per day 0 1 2 3 4 5 6 7+
- **liquor:** _______ days per week _______ per day 0 1 2 3 4 5 6 7+
- **marijuana:** _______ days per week _______ per day 0 1 2 3 4 5 6 7+
- **cocaine/crack:** _______ days per week _______ per day 0 1 2 3 4 5 6 7+

Other illicit/recreational drugs (e.g., Ecstasy/XTC, methamphetamine, etc.):

- **type #1:** _______ days per week _______ per day 0 1 2 3 4 5 6 7+
- **type #2:** _______ days per week _______ per day 0 1 2 3 4 5 6 7+
- **type #3:** _______ days per week _______ per day 0 1 2 3 4 5 6 7+

Have you ever, for any reason, used more of a prescription medication (e.g., Oxycontin, Oxycodone, etc.) than was prescribed, or used a prescription medication for any reason other than why it was prescribed? __ yes __ no

*If yes, what medication(s)? Why? How much? For how long?*

- **type #1:**
- **type #2:**
- **type #3:**

If you smoke **tobacco**, then how many packs of cigarettes do you smoke per week? _______ Per day? _______

At what time of day do you usually have your first (tobacco) cigarette? _______

If you drink colas, teas, or coffees, how many **caffeinated** beverages do you tend to drink in a day? _______

At what time of day do you usually have your first caffeinated beverage? _______

Have you ever been accused of, charged with, and/or convicted of any alcohol or drug related violation or crime? __ yes __ no

*Explain (the charge, when, whether or not you were convicted, etc.):*

Have you ever received **INPATIENT** or **RESIDENTIAL** treatment for alcohol and/or drug abuse or dependence? __ yes __ no

*Name of facility or hospital __________________ __________________ From: ______ To: ______

From: ______ To: ______

Have you ever experienced any social/legal/job-related/academic or other difficulties due to alcohol or other drug use? __ yes __ no

*If yes, please describe briefly:*

Have you ever received **OUTPATIENT** treatment for alcohol and/or drug abuse or dependence? __ yes __ no

*Type of service __________________ For what type of condition(s) or concern(s) __________________ When started? __________________ For how long? __________________

Have you ever attended **Alcoholics Anonymous (AA)**, **Narcotics Anonymous (NA)**, **Al-Anon**, or any other type of support group? __ yes __ no

*Type of group: __________________ From when: ______ To: ______

Type of group: __________________ From when: ______ To: ______
VII. MEDICAL/NEUROLOGICAL HISTORY

To your knowledge:
Were you born prematurely?  ____ yes  ____ no  If yes, at how many weeks were you born?  ____________

What was your birth weight, in pounds and ounces?  ____________________________

Did you or your mother have any difficulties during your delivery/birth?  ____ yes  ____ no

If yes, then what type(s)?  ____________________________

Did your mother use alcohol, tobacco products, cocaine, heroine, or other drugs during her pregnancy with you?  ____ yes  ____ no  Explain:  ____________________________

Was she exposed to environmental toxins, such as DDT, lead, mercury, PCB, etc. during her pregnancy with you?  ____ yes  ____ no  Explain:  ____________________________

Did your mother have any nutritional deficiencies, diabetes, viral infections, or other diseases during her pregnancy with you?  ____ yes  ____ no  Explain:  ____________________________

Were forceps ("tongs") used to deliver you?  ____ yes  ____ no  Why?:  ____________________________

To your knowledge, did you have any difficulty learning to walk, to talk, with toilet training, or with adjusting to attending kindergarten/daycare/school (i.e., in reaching "developmental milestones")?  ____ yes  ____ no

Explain:  ____________________________

Have you ever been seriously injured or ill (e.g., premature birth, cancer, pneumonia, mononucleosis, auto accident, sports injury, job-related injury, extreme fevers [e.g., 104 F or higher], etc.)?  ____ yes  ____ no

<table>
<thead>
<tr>
<th>Type of illness or injury</th>
<th>At what age?</th>
<th>Require hospitalization?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>____ yes  ____ no</td>
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<td>____ yes  ____ no</td>
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<td>____ yes  ____ no</td>
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<td>____ yes  ____ no</td>
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</tbody>
</table>

Have you ever experienced a seizure, a serious head injury, electrocution, poisoning, one or more instances of high fevers (e.g., 103 degrees or higher), or other potential damage to your brain or nervous system?  ____ yes  ____ no

<table>
<thead>
<tr>
<th>Type of seizure, injury, poisoning, or damage:</th>
<th>At what age?</th>
<th>Lose consciousness? (if so, for how long?)</th>
<th>Medical exam?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>no  ____ yes,  ____ no</td>
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<td>no  ____ yes,  ____ no</td>
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</table>

* If you have any experienced a serious injury to your head:

Was your skull fractured?  ____ yes  ____ no

Did you lose consciousness?  ____ yes  ____ no  For how long?

Describe the injury and how it happened:  ____________________________

When did this occur (date of event, your age at that time)?  ____________________________

* If you have ever had a neurological exam (e.g., CAT scan, an MRI, PET scan, etc.):

When?  ____________________________

What type(s) of test(s)?  ____________________________

For what reason?  ____________________________

What were the results?  ____________________________
* If you have ever had a seizure of any type:
  What type(s)? ___________________________________________ When was first? ________________
  How often? ____________________________________________ How recently? ________________
  What sorts of things do you experience when you have a seizure? ____________________________________________

VIII. CURRENT MEDICAL STATUS

Your primary care physician(s)'s name: _______________________________________________________________

Name and address of the facility/office/clinic you go to: _____________________________________________

___________________________________________________________________________________________

His/Her phone number: __________________________ How long has it been since your most recent physical exam? ______________

Are you predominantly ___ right-handed ___ left-handed ___ ambidextrous

Do you have any difficulties with your vision, hearing, coordination, or other sensations/abilities? ___ yes ___ no
  If yes, please explain: ________________________________________________________________
  Corrective measures (e.g., eyeglasses/contacts, hearing aids, etc.): _________________________________

Do you currently have any medical conditions, concerns, or physical discomforts? ___ yes ___ no

Disease/disorder, concern, discomfort: _______________________________________________________________________

Since when (as specific as possible)? _______________________________________________________________________

Do you ever experience attacks or spells characterized by disorientation, confusion, feeling strange, when you cannot control your muscles or movements? ___ yes ___ no

If "yes" then place a check next to any of the following that apply to you:
  ___ Are such periods ever preceded by any unusual sensations (e.g., abdominal fullness/pressure/rising feeling)?
  ___ Are such periods ever followed perhaps by fatigue and/or headache, possibly with poor memory (or even complete amnesia) after the event?
  ___ Do you ever fall down at any time during the event?
  ___ Do you experience any muscle jerks during the event (convulsions)?
  ___ Are any such events preceded by a few hours or even days of altered/unusual mood?

Place a check next to any of the following that apply to you:
  ___ Any experiences (possibly told to you by others) of sudden, repetitive behaviors “out of the blue” that you don’t feel you control? (e.g., lip smacking, chewing, gagging, tapping, spitting, grimacing, spitting, laughing)
  ___ Any experience of strong smells and/or tastes “out of the blue”
  ___ Any experience of flashes of light, lines, animated figures, or other unusual visual percepts
  ___ Any experience of objects appearing too small, too large, or otherwise distorted
  ___ Any experience of auditory clicks, buzzes, voices, music, etc “out of the blue”
  ___ Any experience of things sounding too soft, too loud, or otherwise altered/distorted
  ___ Any experience of a sense of profound meaning, of extreme significance during an event or “out of the blue”
  ___ Any experience of sudden intense terror/panic, rage, depression, anxiety, “out of the blue” that resolves quickly
  ___ Any experience of things feeling unreal, of your body feeling unreal or not your own (derealization)
  ___ Any experiences of things feeling as if you’ve been through them before (déjà vu)
  ___ Any experiences of thoughts or memories intruding into your mind with unusual force
  ___ Are you one to write a great deal, sometimes to the amazement or even annoyance of others
  ___ Have you ever experienced any notable decrease (or increase) in sexual activity, interest, or targets of sexual interest
IX. MEDICATIONS & ALLERGIES

Are you currently taking any prescription or over-the-counter medications, including homeopathic substances (e.g., St. John’s wort, ginseng, etc.)? 

<table>
<thead>
<tr>
<th>medication/substance</th>
<th>For condition/reason?</th>
<th>Dosage/amount per day</th>
<th>Since when (specifically)?</th>
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Are you allergic to any forms of medications or to anything else (e.g., shellfish, soap, pollen, pet dander, etc.)? 

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<tr>
<th>Thing you are allergic to:</th>
<th>Since when (as specific as possible)?</th>
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X. FAMILY HISTORY

To your knowledge, do any of your immediate or distant relatives have any history of emotional, behavioral, psychological, or psychiatric difficulties or disorders (e.g., depression, PTSD, anxiety, schizophrenia, bipolar disorder, "manic-depressive" disorder, "nervous breakdown," obsessive-compulsive disorder, etc.)? 

<table>
<thead>
<tr>
<th>His/Her relation to you</th>
<th>Type of disorder or difficulty</th>
<th>Has he/she ever been treated for it?</th>
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To your knowledge, do any of your immediate or distant relatives have any history of learning disorder(s) or Attention-Deficit/Hyperactivity Disorder? 

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<th>His/Her relation to you</th>
<th>Type of disorder or difficulty</th>
<th>Has he/she ever been treated for it?</th>
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Do any of your immediate or distant relatives have any history of difficulties with alcohol/drugs? 

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<th>His/Her relation to you</th>
<th>Type of disorder or difficulty</th>
<th>Has he/she been treated for it?</th>
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Do any of your immediate or distant relatives have a history of serious medical or health-related concerns (e.g., high blood pressure, cancer, stroke, heart disease, Alzheimer’s Disease, other dementias, etc.)? 

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<tr>
<th>His/her relation to you</th>
<th>Type of disease, disorder, or difficulty</th>
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12
XI. DEVELOPMENTAL, EDUCATIONAL and SOCIAL HISTORY

You are the 1st 2nd 3rd 4th 5th other -born child out of _______ (number of children in your family)?

Have you ever had difficulties (e.g., legal) with, or as a result of, your temper/anger/aggression? ___ yes ___ no
If yes, please explain: ________________________________________________________________

Have you ever been charged with and/or convicted of a misdemeanor crime or felony? ___ yes ___ no
Explain (the charge, when, whether or not you were convicted, etc.): ____________________________

Are you currently involved in any litigation or legal proceedings? ___ yes ___ no
Explain (what type of litigation, for what reasons, etc.): _______________________________________

Mother’s highest education level: ___________________________ Father’s: _______________________

Schools you have attended

<table>
<thead>
<tr>
<th>Public, or private?</th>
<th>What years?</th>
<th>Area(s) of study</th>
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What grades/marks did you receive in elementary school? ________________________________
In what areas did you excel or do particularly well? _________________________________
In what areas did you fail or do particularly poorly? ________________________________

What grades/marks did you receive in middle school? ________________________________ GPA: __________
In what areas did you excel or do particularly well? ________________________________
In what areas did you fail or do particularly poorly? ________________________________

What grades/marks did you receive in high school? ________________________________ GPA: __________
In what areas did you excel or do particularly well? ________________________________
In what areas did you fail or do particularly poorly? ________________________________

What grades/marks do you receive in college? ________________________________ GPA: __________
In what areas did you excel or do particularly well? ________________________________
In what areas did you fail or do particularly poorly? ________________________________

SAT scores: Verbal = _______ Math = _______ Total = _______
GRE scores: General = _______ Subject = _______

Did you have any difficulties with starting school in kindergarten or first grade? ___ yes ___ no
If yes, please explain: ________________________________________________________________

Have you had any history of difficulties learning to read, spell, use grammar/punctuation properly? ___ yes ___ no
If yes, please explain: ________________________________________________________________

Have you ever had trouble doing homework? ___ yes ___ no
If yes, then what type(s) of difficulty? _________________________________________________

What do you do (or, have you done in the past) to compensate for the difficulty? ________________
Were you ever in any special classes in school, or receive any type of remedial instruction?  
   __ yes  __ no  
   If yes, please explain:  

__________________________________________________________

Did you ever repeat a grade for any reason?  
   __ yes  __ no  
   If yes, please explain:  

__________________________________________________________

Have your parents or teachers ever complained that you were difficult to control as a child?  
   __ yes  __ no  
   If yes, around what age did they first have this complaint?  

__________________________________________________________

Did you ever get into physical fights at school (or any where else)?  
   __ yes  __ no  
   If yes, please explain:  

__________________________________________________________

Have you ever been suspended or expelled?  
   __ yes  __ no  
   If so, in what grade(s), and why?  

__________________________________________________________

Have you ever been evaluated for (or been told that you have) a "learning disability," learning disorder, or an Attention-Deficit (with or without hyperactivity) Disorder (ADHD)?  
   __ yes  __ no  
   By whom?  
   When?  
   Diagnosis/disorder(s)?  

__________________________________________________________

NOTE: IF YOU HAVE EVER BEEN FORMALLY EVALUATED BY ANYONE, PLEASE PROVIDE A COPY OF THE REPORT, OR HAVE ONE FORWARD TO US AT THE EARLIEST CONVENIENCE BY YOUR EVALUATOR.

XII. WORK/VOCATIONAL HISTORY  

What is your current occupation?  
   Name of your business or employer:  
   How long with this business/employer?  
   Describe your satisfaction, or lack of satisfaction, with your job/work situation:  

__________________________________________________________

Have you had any difficulties getting jobs, keeping jobs, getting along with employers/co-workers?  __ yes  __ no  

__________________________________________________________

Have you ever been fired or asked to resign?  
   __ yes  __ no  
   Most recent time: please explain:  
   From what position(s)?  
   When?  

__________________________________________________________

   First time: please explain:  
   From what position(s)?  
   When?  

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XIII. IMPACTS ON LIFE FUNCTIONING

<table>
<thead>
<tr>
<th></th>
<th>Not at all true</th>
<th>Moderately true</th>
<th>Severely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to study effectively:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to attend classes:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to complete assignments:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to fulfill job demands:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to concentrate/focus:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to meet others:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to maintain friendships:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to approach others for help:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to tolerate aloneness</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to manage uncomfortable feelings:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
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<tr>
<td>Unable to manage impulses:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to refrain from alcohol/drug use/misuse/abuse:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
<tr>
<td>Unable to experience good health:</td>
<td>1 2</td>
<td>3 4 5</td>
<td>6 7 N/A</td>
</tr>
</tbody>
</table>

How many days of school/work have you missed in the last 30 days due to:
medical/physical problems? _____  stress/mental/emotional difficulties? _____  sleep difficulties/fatigue? _____

XIV. GOALS/OBJECTIVES FOR PSYCHOLOGICAL CONSULTATION(S)

Please list your primary goals/needs for our consultations (e.g., ways in which you believe you want or need to be THINKING, FEELING, and/or BEHAVING differently). Please be as specific as possible.

1. _____________________________________________________________

2. _____________________________________________________________

3. _____________________________________________________________

4. _____________________________________________________________

5. _____________________________________________________________

6. _____________________________________________________________

Your signature: ________________________  Date questionnaire completed: _______________
XV. FOR THOSE SEEKING PSYCHOEDUCATIONAL ASSESSMENT/TESTING FOR LEARNING DISORDERS AND/OR ATTENTION-DEFICIT/ HYPERACTIVITY DISORDERS

We most likely will need to contact additional persons for information to aid in this assessment now or in the near future. PLEASE PROVIDE EACH OF THE FOLLOWING:

I. Mother’s full name: __________________________________________
   Mailing address: _____________________________________________
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________
   daytime phone: ______________________________________________

II. Father’s full name: _________________________________________
    Mailing address: __________________________________________
    _________________________________________________________
    _________________________________________________________
    daytime phone: ___________________________________________

III. Full name of SPOUSE or SOMEONE ELSE who currently knows you well and spends time with you:
    Mailing address: __________________________________________
    _________________________________________________________
    _________________________________________________________
    daytime phone: ___________________________________________

IV. Names of two teachers/instructors from grades 1 – 12 (the earlier, e.g., 1st – 6th grades, the better):
    Teacher/instructor #1: _______________________________________
    Mailing address: ___________________________________________
    _________________________________________________________
    _________________________________________________________
    daytime phone: ___________________________________________

    Teacher/instructor #2: _______________________________________
    Mailing address: ___________________________________________
    _________________________________________________________
    _________________________________________________________
    daytime phone: ___________________________________________

MUST READ AND SIGN: By my signature, I authorize Dr. Brian K. Sullivan and/or his agents to interview by phone, in person, and/or by mail any and all of the persons listed above, for the purpose of psychodiagnostic assessment, for no more than six months after the date of my signature, below.

Your signature: _____________________________________________

Date you completed this questionnaire: ____________________________

VERY IMPORTANT NOTE: For psychoeducational assessments, it is essential that you collect and provide to us copies of any and all report cards, work performance rating reports, transcripts, previous psychological evaluation/assessment reports, and any other documented indications of your performance and abilities in academic, vocational, intellectual, emotional, and behavioral capacities. Please begin to collect these immediately from as many potential sources as you can. Original copies will be returned to you at the conclusion of our assessment process.