Behavioral Diagnostics & Treatment

Antonia Forster, Ph.D., ABPP Michael J Fulop, Psy.D. Ana Cragnolino, Ph.D.

2130 SW Jefferson St., Suite 300, Portland, Oregon 97201-7711

Adult Personal Information Form

First Name: _____ Last Name: _____ DoB: ____/____/____ Today's Date: ____/____/____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: ____-____-_____ Alternate Phone: ____-____-_____ Email: _____@_____

Occupation: _____ In School? ☐ Yes ☐ No If Yes, where? _____ Grade/Year: _____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Religion: _____ How often do you attend services (if applicable)?_____

Who referred you to us for psychological services? _____

What are some of your goals, or what might you like to discuss or accomplish?

_____ _____

_____ _____

What steps have you taken to address these issues already?

_____ _____

_____ _____

How long ago did your issues begin? _____

Why is it important to begin now? _____

List any psychiatrists, psychologists, counselors, or social workers you've seen: _____ _____

Have you undergone psychological assessment services in the past? ☐ YES ☐ NO If so, when?_____

If so, what was helpful about the assessment(s)? _____

What was NOT helpful about the assessment(s)? _____

Family Members: Please list family members and others in relationships with you. Include children.

Name	**Relation**	**Age**	**Education**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Education: Schools Attended	**Dates:**
_____	_____
_____	_____
_____	_____
_____	_____

Do you recall having trouble with any of the following in ELEMENTARY SCHOOL?

Learning to read: ☐ Yes ☐ No

Learning to do math: ☐ Yes ☐ No

Paying attention in class: ☐ Yes ☐ No

Completing homework: ☐ Yes ☐ No

Were you on an Individualized Educational Plan (IEP) or section 504 plan in elementary school: ☐ Yes ☐ No

If so, what IEP or 504 plan accommodations did you use in elementary school? _____

What was most challenging for you in elementary school? _____

Do you recall having trouble with any of the following in MIDDLE SCHOOL?

Reading Projects: ☐ Yes ☐ No

Writing Papers: ☐ Yes ☐ No

Paying attention in class: ☐ Yes ☐ No

Paying attention at home: ☐ Yes ☐ No

Completing long-term projects: ☐ Yes ☐ No

Completing homework: ☐ Yes ☐ No

Procrastination: ☐ Yes ☐ No

Test Anxiety: ☐ Yes ☐ No

Other challenges: _____

Were you on an Individualized Educational Plan (IEP) or section 504 plan in middle school or high school? ☐ Yes ☐ No

If yes, what accommodations did you use in middle school? _____

What was most challenging for you in Middle School? _____

Do you recall having trouble with any of the following in HIGH SCHOOL?

Reading Projects: ☐ Yes ☐ No

Writing Papers: ☐ Yes ☐ No

Paying attention in class: ☐ Yes ☐ No

Paying attention at home: ☐ Yes ☐ No

Completing long-term projects: ☐ Yes ☐ No

Completing homework: ☐ Yes ☐ No

Procrastination: ☐ Yes ☐ No

Test Anxiety: ☐ Yes ☐ No

Other challenges: _____

Were you on an Individualized Educational Plan (IEP) or section 504 plan in middle school or high school? ☐ Yes ☐ No

If yes, what accommodations did you use in high school? _____

What was most challenging for you in middle school? _____

High School Graduation Date (if applicable): _____ GPA at graduation: _____

SAT Scores: Critical Reading: _____ Math: _____ Writing: ____ Composite: ____

ACT Composite Score: ____

Extracurricular Activities in High School (clubs, activities, sports):_____

Do you recall having trouble with any of the following in COLLEGE (if applicable)?

Reading Projects: ☐ Yes ☐ No

Writing Papers: ☐ Yes ☐ No

Paying attention in class: ☐ Yes ☐ No

Paying attention at home: ☐ Yes ☐ No

Completing long-term projects: ☐ Yes ☐ No

Completing homework: ☐ Yes ☐ No

Procrastination: ☐ Yes ☐ No

Test Anxiety: ☐ Yes ☐ No

Other challenges: _____

Did you use accommodations in college? _____

What was most challenging for you in college? _____

College Graduation Date: _____ GPA: _____ Major: _____

Post-Graduate Education (if applicable):

Degree earned	School	Date Degree Granted
_____	_____	_____
_____	_____	_____

Mental health, drug or alcohol, anxiety or other adjustment problems in high school or college? Please describe

_____

_____

Other comments about school or education:

_____

_____

Current Employer:_____ Since:_____

How satisfied are you with your present job on a scale from 0 (lowest) – 7 (highest)? _____

What is stressful about your present job? _____

What would you like to be doing? _____

Employment History: List all employment you've had, including the military during and since high school

Employer	How Long?	Job Title	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Name	Living?	Age	Occupation	Years of Education
Mother: _____	☐ Yes ☐ No	____	_____	_____
Father: _____	☐ Yes ☐ No	____	_____	_____
Sibling: _____	☐ Yes ☐ No	____	_____	_____
Sibling: _____	☐ Yes ☐ No	____	_____	_____
Sibling: _____	☐ Yes ☐ No	____	_____	_____

Do any of your FAMILY MEMBERS suffer from these problems? *(Consider family as brothers, sisters, parents, grandparents, aunts, uncles, cousins)*

Condition	**Mother's Family** (List relation)	**Father's Family** (List relation)
Learning Issues	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Depression	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Alcohol or Drug Problems (Specify):_____	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Mental Retardation	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Legal Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Hyperactivity	Relation: _____ Relation: _____	Relation: _____ Relation: _____

Anxiety Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
OCD	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Perfectionism	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Language, Speech, or Hearing Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Tics or Nervous Habits	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Mood/Emotion Regulation Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Anger Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Psychiatric Hospitalization	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Other (List): _____	Relation: _____ Relation: _____	Relation: _____ Relation: _____

Health Information

Your Physician: _____ Physician Phone: _____-_____-_____ Date of last physical exam: ___/___/___

Please list the conditions, medications, etc.:

Current Health Conditions? ☐ Yes ☐ No _____ _____ _____ _____

Current Medications? ☐ Yes ☐ No _____ _____ _____ _____

Taking Supplements? ☐ Yes ☐ No _____ _____ _____ _____

Supplements to Treat: _____ _____ _____ _____

Please check any of the following that are/were concerns for you now/in the past:

Alcohol problems: ☐ Now ☐ Past
Anger management: ☐ Now ☐ Past
Anxiety problems: ☐ Now ☐ Past
Behavior problems: ☐ Now ☐ Past
Computer (too much): ☐ Now ☐ Past
Depression: ☐ Now ☐ Past
Drug problems: ☐ Now ☐ Past
Developmental issues: ☐ Now ☐ Past
Emotion regulation: ☐ Now ☐ Past
Gambling: ☐ Now ☐ Past
Hyperactivity: ☐ Now ☐ Past
Inattention issues: ☐ Now ☐ Past
Learning: ☐ Now ☐ Past
Legal Issues: ☐ Now ☐ Past
Memory issues: ☐ Now ☐ Past
Mood regulation: ☐ Now ☐ Past
Obsessions issues: ☐ Now ☐ Past
Organization problems: ☐ Now ☐ Past
Perfectionism: ☐ Now ☐ Past
Procrastination: ☐ Now ☐ Past
Psychiatric/Res. Treatment: ☐ Now ☐ Past
Regimen adherence: ☐ Now ☐ Past
Sleep Problems: ☐ Now ☐ Past
Tics: ☐ Now ☐ Past
Video gaming: ☐ Now ☐ Past
Other Issues: ☐ Now ☐ Past If so, please list: _____

Please check any of the following that were concerns your parents had about you at any time:

Alcohol problems: ☐ Now ☐ Past	Anger management: ☐ Now ☐ Past	Anxiety problems: ☐ Now ☐ Past
Behavior problems: ☐ Now ☐ Past	Computer (too much): ☐ Now ☐ Past	Depression: ☐ Now ☐ Past
Drug problems: ☐ Now ☐ Past	Developmental issues: ☐ Now ☐ Past	Emotion regulation: ☐ Now ☐ Past
Gambling: ☐ Now ☐ Past	Hyperactivity: ☐ Now ☐ Past	Inattention issues: ☐ Now ☐ Past
Learning: ☐ Now ☐ Past	Legal Issues: ☐ Now ☐ Past	Memory issues: ☐ Now ☐ Past
Mood regulation: ☐ Now ☐ Past	Obsessions issues: ☐ Now ☐ Past	Organization problems: ☐ Now ☐ Past
Perfectionism: ☐ Now ☐ Past	Procrastination: ☐ Now ☐ Past	Psychiatric/Res. Treatment: ☐ Now ☐ Past
Regimen adherence: ☐ Now ☐ Past	Sleep Problems: ☐ Now ☐ Past	Tics: ☐ Now ☐ Past
Video gaming: ☐ Now ☐ Past	Other Issues: ☐ Now ☐ Past	If so, please list: _____

Your Personal Strengths: _____

Your Important Values: _____

Your Coping Style: _____

Have you had any driving problems?

How many speeding tickets have you received since obtaining your license? _____

How many moving violations have you received since obtaining your license? _____

How many accidents have you been involved in since obtaining your license? _____

Have you ever had your license restricted, revoked, or suspended? ☐ Yes ☐ No

What would you like to be doing differently in 3 months?

_____

_____

What would you like to be doing differently in 6 months?

_____

_____

What would you like to be doing differently in 1 year?

_____

_____

What would you like to be doing differently in 5 years?

_____

_____

Any other information you might like to convey about yourself:

_____

_____

_____