Colorado Center *for*
Assessment & Counseling
KNOWLEDGE *to* THRIVE

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Fort Collins, CO 80526

General Information

Date: _____ Date of Birth: _____ Age: _____

Full Name: _____

Address (include zip): _____

Phone: Home: _____ Is it okay to leave a detailed message at this number? Yes __ No __

Cell: _____ Is it okay to leave a detailed message at this number? Yes __ No __

E-Mail Address: _____

Do I have your consent to email an appointment reminder prior to sessions? Yes _____ No _____

Do I have your consent to email digital copies of:

1) Records: Yes _____ No _____

2) Billing statements: Yes _____ No _____

Emergency contact name: _____

Phone #: _____ Email Address: _____

Please tell me a little more about you:

Gender: _____

Ethnicity/Cultural identity: _____

Spiritual beliefs: _____

Disability (if any): _____

Sexual orientation: _____

Occupation and/or School & Major: _____

Handedness (right/left/ambidextrous): _____

Who referred you to our service? Please provide contact information: _____

_____

Is this referral a result of or related to any legal or court proceedings? If so please provide name of attorney.

_____

Please list the reason(s) you are seeking this evaluation:

_____

_____

_____

How long have these problems occurred? (number of weeks, months, years)_____

Have you had previous neuropsychological testing? **Yes No**

If Yes, where? _____When? _____

Have you had any additional testing (e.g., psychoeducational, speech/language?) **Yes No**

If Yes, where? _____ When? _____
**If you answered Yes to either of the above questions, please attach or otherwise provide report(s).*

Please list any other healthcare providers involved in your care (e.g., neurologists, other physicians, occupational therapists, etc.): _____

_____

_____

Developmental/Medical History

Pregnancy and Birth (your own, not your children's – leave blank if unknown)

Pregnancy/Birth/Delivery Complications? Please Describe _____

_____

Medications used during pregnancy? _____

Did your mother engage in any of the following during pregnancy?

Yes No Smoking? How much? _____
Yes No Drug intake? Type? _____ How much? _____
Yes No Alcohol consumption? How much? _____

Length of pregnancy? _____ (weeks) Age of mother at birth: _____
Birth weight: _____ lbs. _____ oz. Birth length: _____ APGAR scores? _____/_____
Type of delivery: _____spontaneous ___induced _____cesarean _____with instruments _____ breech

Any complications for mother or infant (yourself) after birth? Please explain:

_____

_____

_____

Developmental Milestones

Yes No Did you enjoy cuddling?
Yes No Were you fussy or irritable?
Yes No Were you more active than other babies?
Yes No Was your development significantly different than your siblings? If yes, please explain:

_____

_____

At what age did you first do the following (indicate with year and month of age).
Turn over _____ Crawl _____ Stand Alone _____ Walk Alone _____
Walk Upstairs _____ First Words _____ First Phrases _____

Toilet Trained during the day by age 5? **Yes** **No**
Did bed wetting or soiling occur after training? **Wetting** **Soiling** If yes, until what age? _____

Did you have any speech difficulties?: _____
Motor difficulties (e.g. clumsiness)?: _____

Medical History

Yes No Has your medical history been normal/unremarkable? If no, please explain: _____

_____

_____

Yes No Have you received any medical diagnoses? Please explain: _____

_____

_____

Yes No Have you completed genetic testing?
Yes No Have you had an MRI?
Yes No Have you had an EEG?
Yes No Frequent ear infections?
Yes No Were ear tubes ever placed?
Yes No Hearing problems?
Yes No Vision problems?
Yes No Headaches?
Yes No Meningitis?
Yes No Seizures?

Yes No Asthma?
Yes No Slow/fast growth?
Yes No Head injury?
Yes No Allergies?
Yes No Hospitalizations?
Yes No Have you experienced anything you would call traumatic (physical, verbal, or emotional abuse; unwanted sexual experiences; accidents or other events)?

Have you ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*
_____	_____	_____
_____	_____	_____

What medications do you currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*
_____	_____	_____	_____
_____	_____	_____	_____

Describe your sleep routine:
Typical bed time: _____ Typical wake time: _____
Trouble falling asleep? **Yes No** Trouble staying asleep? **Yes No** Trouble waking up early? **Yes No**
Any other sleep problems? Explain: _____

_____

Describe your diet: _____

_____

Describe your current level and type(s) of exercise: _____

_____

_____

Mental Health History:

List any previous or current mental health diagnoses: _____

_____

Have you received therapy services or counseling in the past? **Yes** **No**
Name of provider:_____ Dates:_____
Name of provider:_____ Dates:_____
Name of provider:_____ Dates:_____

Are you currently seeing a psychiatrist for medication? **Yes** **No** Have you in the past? **Yes** **No**
Name of Psychiatrist:_____ Dates of treatment:_____
Medication the Psychiatrist Prescribed:_____

Is there a history of self-harm or suicidal thoughts, threats, or attempts? Please explain: _____

_____

Have you ever been hospitalized for mental health concerns? Please explain:_____

_____

Psychosocial Functioning

Describe your personality: _____

_____

_____

What are your non-academic strengths?

_____

What are your non-academic weaknesses?

_____

How do you spend your free time?

_____

_____

What is your current level of alcohol and/or drug use?
Alcohol: _____
Recreational drugs: _____

How is your social group? Do you have close friends? Any trouble initiating or maintaining relationships?

_____

_____

_____

_____

Please place a mark next to behaviors that you believe you experience to an *excessive or exaggerated degree* when compared to others your age.

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Decreased need for sleep without getting tired
- ❑ Eating Poorly
- ❑ Eating excessively
- ❑ Excessive snoring during sleep

Social

- ❑ Prefer to be alone
- ❑ Excessively shy or timid
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Not sought out for friendship by peers
- ❑ Excessive daydreaming and fantasy life
- ❑ Difficulty seeing another person's point of view
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with others
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Impulsive (does things without thinking)
- ❑ History of vocal or motor tics
- ❑ Poor sense of danger/risk
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug use
- ❑ Alcohol use

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ "Clumsy" in general

Academic History

Did you ever have an IEP or 504 Plan, or other modified learning program or participation in special education services when younger? **Yes** **No**

If yes, please describe:

What was your high school GPA: _____
What was/is your college GPA: _____ Grad school GPA: _____

How do you generally perform on standardized tests?

What are your strongest and weakest points, academically?

Legal History

Have you been involved with the court currently or in the past? _____
Date(s): _____
Describe: _____

Current Probation? **Yes** **No** Probation Officer: _____ Phone #: _____

Family History

Are you (choose one): **Married** **Separated** **Divorced** **Living Together** **Single**
If married, for how long? _____
If separated or divorced, when? _____
Do you have children? Ages? _____
Who else lives in your home? _____

Have any of the following diseases occurred among your blood relatives (parents, aunts, uncles, grandparents)? Check those that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD
- ❑ Bleeding tendency
- ❑ Depression
- ❑ Cancer
- ❑ Suicide
- ❑ Learning problems
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety
- ❑ Autism/Asperger's
- ❑ Intellectual disability/cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Other (specify): _____