virginia lindahl Ph.D.
Therapy and Psychological Testing

PSYCHOLOGICAL ASSESSMENT BACKGROUND INFORMATION
ADULT CLIENTS

	Today's Date	
Who referred you?		
CLIENT INFORMATION		
Last Name	First Name	
Address		
Home phone number	Cell phone number	
Occupation		
FAMILY HISTORY		
Mother's occupation	Mother's highest level of education	
Father's occupation	Father's highest level of education	
Primary language spoken during childhood	Secondary language spoken during childhood	
Please check any illness or condition that any member of your immediate family (birth parents, siblings, half siblings, aunts or uncles, grandparents) has had. Indicate which family member and describe.		
Illness or Condition		Family Member
Depression	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Obsessive-Compulsive Disorder	☐ Yes ☐ No	

Suicidality	☐ Yes ☐ No	
Learning disabilities	☐ Yes ☐ No	
Hyperactivity	☐ Yes ☐ No	
Attention Deficit/Hyperactivity Disorder (ADHD or ADD)	☐ Yes ☐ No	
Repeated a grade	☐ Yes ☐ No	
Needed special education or tutoring	☐ Yes ☐ No	
Any psychiatric or psychological problems for which treatment was received	☐ Yes ☐ No	

MEDICAL AND DEVELOPMENTAL HISTORY

Please answer to the best of your knowledge.

During pregnancy, was mother on medication?	☐ Yes ☐ No	If yes, what medication and for what reason?
During pregnancy, did mother smoke?	☐ Yes ☐ No	If yes, how many cigarettes a day?
During pregnancy, did mother drink alcoholic beverages?	☐ Yes ☐ No	If yes, How many drinks a day? What did she drink?
During pregnancy, did mother use drugs?	☐ Yes ☐ No	If yes, how many drinks a day?
Were forceps used during delivery?	☐ Yes ☐ No	
Was a Caesarian section performed?	☐ Yes ☐ No	If yes, for what reason? Was it an emergency C-section?

Were you born prematurely?	☐ Yes ☐ No	If yes, how many weeks prematurely? What was the reason for premature delivery?
What was your weight at birth?		
Describe any birth defects or complications during delivery.		
Describe and feeding or sleeping problems during infancy.		
Describe any special problems in your growth or development during the first few years.		
Please indicate if you met the following developmental milestones on time. If not, please indicate if you met them early or late and to what degree.		
Showed response to mother	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Rolled over	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Sat alone	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Crawled	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Fed self	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?

Rode tricycle	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Put several words together	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Dressed self	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Became toilet trained	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Stayed dry at night	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Spoke first word	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?
Walked	☐ Early ☐ On time ☐ Delayed ☐ Unsure	If early, how early? If delayed, how delayed?

Please circle if you have had any of the following medical conditions:

Measles	German Measles	Mumps	Chicken Pox
Diphtheria	Whooping Cough	Scarlet Fever	Meningitis
Encephalitis	High Fever	Convulsions	Head Injury
Allergies	Broken Bones	Hospitalizations	Fainting Spells
Paralysis	Dizziness	Headaches	Memory Problems
Epilepsy	Tuberculosis	Visual Problems	Rheumatic Fever
Hearing Problems	Gonorrhea	Syphilis	Jaundice/Hepatitis
Diabetes	Cancer	High Blood Pressure	Heart Disease
Asthma	Asthma	Suicidality	Difficulty Concentrating

Stomach Problems	Obesity	Other (specify):

Please provide ages for any of the conditions circled above:

Are you currently taking any medication?

- ☐ Yes
- ☐ No

If yes, please list current medication names, dosages, and reason for taking:

Please list previous medications, when taken, for how long, and in what combinations (including past trials of medications for attention, depression, anxiety, etc.)

EDUCATIONAL AND OCCUPATIONAL HISTORY

Please list all schools and major employers, starting with the most recent.

Name of School or Employer	Grades Attended or Years Employed	City/State

Elementary School

How did you perform academically?

What was harder or easier for you?

Did you have any behavior problems?

Middle School/Junior High School

How did you perform academically?

What was harder or easier for you?

Did you have any behavior problems?

High School

How did you perform academically?

What subjects were easier or harder for you?

Did you have any behavior problems in high school?

College

If you went to college, how did you perform academically?

What subjects were harder or easier for you?

Did you have any behavior problems?

TREATMENT HISTORY

Is this the first time you have undergone educational, intellectual, developmental, behavioral, or emotional testing?

If this is not your first evaluation, describe the reasons for testing, the dates of testing, and the findings, if known. Who performed the evaluation?

Have you ever received formal or informal accommodations at school or work for learning, attention, executive functioning problems or other deficits? These might include extended time, permission to complete assignments in a resource room, etc. If so, please describe:

List all previous treatment, if any, you have received for the current problem (including tutoring, speech and language therapy, occupational therapy, psychotherapy, etc.)

Treated by	Type (e.g. occupational therapy)	Dates

Have you ever been held back a grade?

- ☐ Yes
- ☐ No

If yes, which one?

OTHER INFORMATION

Why are you seeking an evaluation now?

When was the problem first noticed?

What are your assets and strengths?

Please list any unusual, traumatic, or possibly stressful events in your life that you think may have had an impact on your development and current functioning. Include the incident, your age at the time, and comments:
Is there any other information that you think would be helpful in any way when working with you?