INTAKE CHECKLIST
LRS/LWC REFERRED EVALUATION

Name: _____ ____ _____ Age: _____ Date of Birth: _____
First Middle Initial Last

Gender: Male _____ Female _____ Race: _____ Today's Date: _____

Home Address: _____ Phone: _____
Street City/State Zip Include Area Code

*MUST COMPLETE ITEMS FOR APPOINTMENT NOTIFICATION

*Cell Phone: _____
Include Area Code

Parents/Guardian Cell Phone:
_____
Include Area Code

*Client's E-Mail:
_____

Counselor Referring You From LRS/LWC:_____

Directions To Completing Checklist:
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This checklist asks many questions about your personal, educational and possibly work history. Many of these questions are difficult to complete. Please try not to skip any of them. Take your time and answer it honestly.

Start by entering your name, age, gender, and today's date at the top of this page. Sign the bottom of the page to assert the credibility of your answers. Then turn to the inside of this booklet and answer all of the questions.

Keep in mind that the best way to formulate an accurate and helpful evaluation is to get good and accurate information from the person evaluated.

PLEASE READ CAREFULLY – EVALUATION CONTRACT

I understand that I should attend the appointment ON TIME. Please call 24-48 hours before the appointment to verify your coming to the appointment. If you can't make the appointment, please call 48 hours ahead of the appointment time. In general missed appointments ARE NOT RESCHEDULED.

_____ _____
Signature of Client or Legal Guardian Date of First Scheduled Appointment

Write Below A List Including Yourself Of All The Individuals Living In Your Residence.
(PLEASE INCLUDE THE NAMED CLIENT)

Name	Age	Education	Occupation	Relation To Client

1. What are your problem(s) today? (List All)

____ A. Have no problem	____ H. Past History of Learning Disorder
____ B. Evaluation of Reading Skills	____ I. Past History of ADHD
____ C. Evaluation of Math Skills	____ J. Problem with Math Word Problems
____ D. Evaluation of Written Language Skills	____ K. Problem with Thinking Clearly
____ E. Evaluation of Attention Span	____ L. Depression
____ F. Evaluation of Over or Hyper Activity	____ M. Anxiety
____ G. Problem with Taking Tests	____ N. Problems with Alcohol
	____ O. Problems with Drugs

2. State, in your own words what you would like to learn from this evaluation.

3. In your own opinion, how severe are your present problems?

(Check One)

Nothing	Mild	Moderate	Severe	Unbearable
_____	_____	_____	_____	_____

4. Which of the following has the problem affected?

(Check All That Apply)

_____ Nothing	_____ School Performance	_____ Health
_____ Work Performance	_____ Family Relationships	_____ Finances

5. Have you been evaluated for this problem before?

_____ No _____ Yes With Some Success _____ Yes With A Lot Of Success

If yes what intervention seemed to work? This can include accommodations and/or medication.

_____

_____

_____

6. What problems have you had in your past? (Check All That Apply)

_____ None	_____ Problems With Written Language
_____ Thinking Problems	_____ Problems With Test Taking
_____ Attentional Problems	_____ Poor Grades On Tests
_____ School Performance Problems	_____ Prior Learning Disability Evaluation
_____ Health Problems	_____ Prior ADHD Evaluation
_____ Problems With Reading	_____ Head Injury Resulting With Even A
_____ Problems With Math	Short Term Loss Of Consciousness

Family Background

7. Who primarily raised+ you?

_____ A. Natural Parents	_____ E. Older Sibling
_____ B. Natural Parent and Step Parent	_____ F. Adoptive Parents
_____ C. Grandparents	_____ G. Foster Parents
_____ D. Aunt and/or Uncle	_____ H. Orphanage

8. When growing up, how many children are or were in your family?

_____ Only Child	_____ 6 Including Yourself
_____ 2 Including Yourself	_____ 7 Including Yourself
_____ 3 Including Yourself	_____ 8 Including Yourself
_____ 4 Including Yourself	_____ 9 Including Yourself
_____ 5 Including Yourself	_____ More Than 9 Including Yourself

9. Of the other children, how many were stepbrothers and stepsisters?
_____ 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6

10. Which order of child in your family were you?
_____ Only Child _____ Youngest _____ Middle _____ Oldest

11. What is your native language? _____

Do you have any other languages you know? _____

12. Father's Level of Education (Last Level Completed)
_____ Elementary _____ High School _____ Some College
_____ College Graduate _____ Postgraduate Work

13. Father's History of Learning or Attentional Problems.
Please describe the types of evaluations or difficulties that the biological father has had.
_____
_____
_____

14. Father's Present Work (Main Type of Work)
_____ Unemployed _____ Disabled _____ Unskilled _____ Skilled Trade
_____ Business Man _____ Professional (Doctor, Lawyer) _____ Sales
_____ Educator

15. Mother's Level of Education (Last Level Completed)
_____ Elementary _____ High School _____ Some College
_____ College Graduate _____ Postgraduate Work

16. Mother's History of Learning or Attentional Problems.
Please describe the types of evaluations or difficulties that the biological mother has had.
_____
_____
_____

17. Mother's Present Work (Main Type of Work)
_____ Unemployed _____ Disabled ____ Unskilled _____ Skilled Trade
_____ Business Woman _____ Professional (Doctor, Lawyer) _____Sales
_____ Educator

18. Describe your father's parenting abilities.
(Check One)
_____ Great _____ Good _____ Average _____ Poor _____ Terrible

19. Describe your mother's parenting abilities.
(Check One)
_____ Great _____ Good _____ Average _____ Poor _____ Terrible

20. Which of the following illnesses or injuries have you had.

_____ None
_____ Do Not Know
_____ Asthma
_____ Polio
_____ Reading Disorder
_____ Math Disorder
_____ Broken bone(s)
_____ Serious Head Injury With Loss of Consciousness
_____ ADHD
_____ Heart Problems

21. Describe your grades in grades 1st – 8th.

_____ Mostly As
_____ Mostly As and Bs
_____ Some Cs
_____ Ds and Fs Predominate

22. Describe your behavior in grades 1st – 8th.

_____ Well Behaved
_____ Routine Problems
_____ Frequent Problems
_____ Suspended
_____ Expelled

23. Describe your social behavior in grades 1st – 8th.

_____ Lots of Friends
_____ Average Number of Friends
_____ Few Friends
_____ Teased a Lot
_____ Fought a Lot
_____ Real Loner

24. Please list what is/was your best subject in school.

_____

25. Please list what is/was your worst subject in school.

_____

28. If applicable describe your grades in grades 9th – 12th.

_____ Mostly As
_____ Mostly As and Bs
_____ Some Cs
_____ Ds and Fs Predominate

29. Describe your behavior in grades 9th – 12th.

_____ Well Behaved
_____ Routine Problems
_____ Frequent Problems
_____ Suspended
_____ Expelled

30. Describe your social behavior in grades 9th –12th.

_____ Lots of Friends
_____ Average Number of Friends
_____ Few Friends
_____ Teased a Lot
_____ Fought a Lot
_____ Real Loner

31. How would you best describe yourself personality wise? (Check no more than 3 or 4 boxes.)

_____ Active
_____ Passive
_____ Happy
_____ Content
_____ Unhappy
_____ Calm
_____ Nervous
_____ Fearful
_____ Moody
_____ Outgoing
_____ Shy
_____ Lonely
_____ Quiet
_____ Noisy
_____ Coordinated
_____ Clumsy
_____ Intelligent
_____ Dull
_____ Other _____

32. Describe the actual amount of education you have acquired. (Check all that apply.)

_____ None
_____ Elementary School
_____ High School Degree or GED
_____ Community College
_____ Trade School
_____ Four Year College
_____ Masters or Doctorate Degree
_____ J.D. or M.D. Degree

33. Name of School City/State Grades Attended Average Grades

Elementary _____
_____
_____
_____
_____

Junior High _____
_____
_____

High School _____
_____
_____

Name of School City/State Subject Area Average Grades
Post High School _____
_____
_____
_____
_____

34. In school which sports did you participate in?_____

35. In school which clubs or activities were you in? _____

36. At any grade were you held back? _____ Yes _____ No
Which grade or grades? _____
_____

37. Have you had any previous intelligence, IQ or educational testing? ____ Yes ____ No
If yes please complete the following:
Year done _____ City/State _____
Place or Evaluator: _____
Diagnoses Remembered: _____

Year done _____ City/State _____
Place or Evaluator: _____
Diagnoses Remembered: _____

Interests and Activities

38. List 3 things you do to have fun.
1. _____
2. _____
3. _____

39. List 3 things that you are proud of.
1. _____
2. _____
3. _____

PLEASE COMPLETE THE FOLLOWING TO ESTABLISH BASELINE LEVELS
(Sometimes changes occur which need to be noted because of either medication or behavioral changes.)

40. Present Height _____ Weight _____ Eye Color _____
Hair Color _____ Glasses/Contacts Yes ____ No ____
Hearing Aide Yes ____ No ____ Any Other Devices? _____
If any describe: _____

41. Please list any accommodations you have had in any educational setting. First start by noting the grades that you had the accommodation in, second note the type of accommodations, state by yes or no if it was helpful.

Grade	Actual Accommodation	Was It Effective
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No

42. Current Medications. List all prescribed and OTC medications that you take regularly.

Medication Name	Dosage/Day	Month/Yr. Started	Physician Prescribing
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

43. Previous Medications. List all prescribed medications you took for more than two months.

Medication Name	Dosage/Day	Date Stopped	Why Stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

44. Is there a Family History (Siblings or Parents only) of any of the following difficulties. (Check all that apply and identify the relationship by saying mother, father, sister, brother.)

_____ Mood Disorder (Depression)
_____ Mood Disorder (Bipolar)
_____ Schizophrenia
_____ Alcohol or Substance Abuse
_____ Dementia <60 Years Old
_____ Anxiety Disorder
_____ Hospitalized for Mental Illness
_____ ADHD or ADD
_____ Reading Disorder
_____ Mental Retardation
_____ Seizure, Epilepsy
_____ Eating Disorder
_____ Obsessive Compulsive
_____ Outpatient Treatment for Mental Illness

45. Are there head or neck complaints currently? (Check all that apply.)

_____ Change in Sense of Smell
_____ Blurry or Double Vision
_____ Facial Numbness
_____ Hearing Loss
_____ Visual Hallucinations
_____ Auditory Hallucinations
_____ Intolerance of Noise
_____ Dizziness
_____ Slurring Speech
_____ Intolerance of Light

46. Are there muscular problems currently?

_____ Loss of Strength
_____ Loss of Coordination
_____ Unstable Walking
_____ Muscle Cramps
_____ Involuntary Tremors
_____ Voluntary Tremors
_____ Tics or Blinking
_____ Slowed Movement

47. Are there mental or cognitive problems currently?

_____ Poor Concentration
_____ Problem Finding Word
_____ Problem Understanding Others
_____ Problem With Note Taking
_____ Problem With Math
_____ Problem Sounding Out Words
_____ Problem Comprehending What is Read
_____ Problem With Word Problems In Math
_____ Problem With Basic Computations In Math
_____ Poor Sense of Direction
_____ Episodes of Getting Lost
_____ Problem Organizing Work
_____ Problem With Handwriting
_____ Problem With Memory

Psychiatric History

48. Check each and any of the mental health professionals you have seen.

_____ Psychiatrist M. D.
_____ Psychologist Ph.D.
_____ Social Worker MSW
_____ Substance Abuse Counselor
_____ Licensed Professional Counselor
_____ Nurse Practitioner
_____ Pastoral Christian Counselor
_____ Physicians Assistant

49. Please describe what you saw the professional for and any diagnoses given.

_____
_____
_____

50. Have you ever received psychological or educational testing?
Yes _____ No _____ If yes, please provide.

Date	Evaluator's Name	City/State
_____	_____	_____
_____	_____	_____

51. Have you ever attempted suicide? Yes _____ No _____ If yes please provide.

Attempt Number	Year	Method Used	Result After
1	_____	_____	_____
2	_____	_____	_____

Substance Use History

52. Have you ever been tested for alcohol or drug use or abuse? Yes _____ No _____
If yes which substances?

_____

53. Do you drink alcohol? Yes _____ No _____

54. Does anyone complain about your drinking, and who? _____

55. Have you used any illicit (street) drugs? Yes _____ No _____

If yes, which ones and when was the last use? _____

56. How many caffeinated beverages do you drink a day?
Coffee _____ Sodas _____ Tea _____ Energy drinks _____

57. Please write below any condition that you have that you wish us to know about.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Previous Employment

58. Job Title	Dates Done Start to Finish	Activity Of This Job	Reason Quit Or Why Fired

59. Describe your experience applying for work recently? Any problems with trying to get a job?

60. Describe relationships with managers and/or bosses in previous work experiences.

61. If you've ever been let go from a job why?

_____

_____

_____

_____

62. Describe your goals for your future education.

_____

_____

_____

_____

63. Describe your goals for your future employment.

_____

_____

_____

_____

_____

_____

_____

_____