

Office Use:

Last Name: _____

Evaluation Date: _____

Evaluation Time: _____



CONFIDENTIAL PERSONAL HISTORY FOR ADULTS

Today's Date: _____

Client Name: _____

Address: _____ Birthdate: _____

Age: _____

Profession: _____

Home phone number: _____ Work phone number: _____

Email: _____

Referred by: _____

May we send a thank you letter to your referral source? yes no

Dynamic Learning Services has my permission to send a thank you letter to my referral source indicating that I have been seen for an evaluation. No other information will be released without written consent.

Signature: _____ Date: _____

Reason(s) for your interest in having an assessment: _____

PERSONAL INFORMATION

Single:_____ Married:_____ Separated:_____ Divorced:_____ Widowed:_____

Name of Spouse:_____

Names and ages of your children:

Name Age (N=natural A=adopted S=stepchild F=foster)

Please describe your current job or status as a student._____

Are you content with your current situation at home, work, or school?_____

DEVELOPMENTAL HISTORY

Please answer these questions as best you can about your own developmental history.

Family Background (N=natural, A=adopted, S=stepchild)

Name	Age	Education/Occupation
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	N A S _____
_____	_____	N A S _____
_____	_____	N A S _____
_____	_____	N A S _____

Please describe any outstanding events which occurred during your mother's pregnancy, labor and delivery or other details regarding your birth experience._____

Please describe any outstanding events which occurred before school age (problems in motor

development, health, language acquisition, major moves of the family, separation of parents, any traumatic events, etc.) _____

Were you adopted? Yes _____ No _____ If yes, at what age? _____

Please describe any information you have about events preceding and following the adoption. _____

SCHOOL

Please outline any difficulties encountered at school. _____

HEALTH

Are you in good general health at the present time? Yes _____ No _____

Are you taking any kind of prescribed medication? Yes _____ No _____

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any major health problems, operations and/or illnesses you have had in the past. _____

Have you suffered or are you presently suffering from any hearing or ear-related problems?

Yes_____ No_____ If yes, please describe:_____

Are you currently involved in any kind of therapy? Yes_____ No_____

If yes, please describe:_____

	Rarely	Sometimes	Often	Comments
Absent-Minded	_____	_____	_____	_____
Easily bored	_____	_____	_____	_____
Difficulty getting organized	_____	_____	_____	_____
Difficulty sleeping	_____	_____	_____	_____
Frequent tiredness	_____	_____	_____	_____
Difficulty regulating eating habits	_____	_____	_____	_____
Difficulty relaxing	_____	_____	_____	_____
Moodiness	_____	_____	_____	_____
Do you enjoy speaking in public?	_____	_____	_____	_____
Do you play a musical instrument? If yes, which one(s)?	_____	_____	_____	_____

OTHER

Is there any other information you believe might be helpful to us in determining the suitability of our program for you? _____

GOALS/OUTCOMES

Please be specific with regard to the goals and outcomes you would like to achieve. How will you measure or evaluate the success of achieving your goals?

Goals/Outcomes

How Measured?

1) _____

2) _____

3) _____

4) _____
