WEAVER CENTER
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ADULT QUESTIONNAIRE

_____ 20_____
Date questionnaire completed

_____ _____
Your Name Last Grade Completed

_____ _____
Date of Birth School

_____
Name of person completing questionnaire (if other than patient)

*****

1. Who suggested an evaluation at this time? _____

2. CHIEF PROBLEM (use additional page if necessary):
   _____
   _____
   _____
   _____

3. Does you have any school/work behavior problems? Please describe:_____
   _____
   _____

4. Does you have any school studies problems (besides chief problem?)
   Please describe: _____

5. Please describe your strengths _____

6. Please describe your weaknesses (other than chief problem)_____

THIS PAGE TO BE USED FOR CONTINUATION OF ANSWERS FROM PAGE 1

Family History

7. Your: e. _____ Age f. _____lb. _____oz. Birthweight

Brothers and/or Sisters: Age:

g. _____ h. _____
i. _____ j. _____
k. _____ l. _____
m. _____ n. _____
o. _____ p. _____

8. Are you _____ biological _____ adopted _____ foster child

9. Who do you live with at present time? (Include parents, brothers, sisters, grandparents, friends, immediate family members, etc.)_____
_____

10. What is the primary language spoken at home? _____

11. What is your mother's education? _____
Occupation? _____

12. What is father's education? _____
Occupation? _____

13. Please list relatives* who are left-handed or "mixed-handed" _____
_____

14. Please list relatives who have (or had) school problems:
(* Family members include: biological parents, siblings, grandparents, aunts, uncles. Please include whether maternal or paternal)

Relatives* Name: Maternal Side	School/Learning Difficulties (language, reading, writing, spelling, mathematics, foreign languages, etc.)
_____	_____
_____	_____
_____	_____
_____	_____

Name: Paternal Side

_____	_____
_____	_____
_____	_____
_____	_____

15. Please list biological relatives with behavior problems

Relatives* Name: Maternal Side	Social/Emotional or Behavioral Difficulties (overactive, restless, withdrawn, trouble with the law, depression, bipolar/Alcohol/Substance Abuse)
_____	_____
_____	_____
_____	_____
_____	_____
Name: Paternal Side	
_____	_____
_____	_____
_____	_____
_____	_____

16. Has any relative suffered from seizures, neurological disease or disorder, emotional problems, mental retardation? If so, please identify diagnosis, treatment, and relationship.
_____
_____
_____

17a. Are you the 1st, 2nd, etc. of mother's pregnancies (please include all pregnancies, miscarriages, if known)_____
b. Complications in pregnancies (if female)_____

18a. Were you full term (born at the expected time)? _____
b. Weeks premature? _____

19. a. Age of mother at delivery? _____
b. Age of father at delivery? _____

<u>Medical History</u> (complete all that is known)

20. Your condition at birth: _____

21. Did you have jarndice, "Rh" problems, chemical abnormalities?_____
a. Seizures/convulsions? _____ b. At what age? _____
c. Were seizures associated with high fever? _____

22. a. Have you had any serious illnesses? If so, what? _____
b. When? _____ c. How long? _____

23. a. Have you ever been hospitalized? If so, why? _____
b. When? _____ c. How long? _____

24. a. Have you ever had any operations? If so, what _____
b. When? _____

25. a. Do you have any allergies? b. If so, to what? _____
_____ c. Treatment _____

26. a. Have you had any head injuries? _____
b.Circumstances? _____
c.When? _____ d.Were you unconscious? _____
e.How long? _____f.Were you dizzy? _____
g.Did you have headaches? _____h. Treatment, if any_____

27. a. Does you have abdominal pains/vomiting? If so, how often? _____
b. When does this occur? _____
c. How is this treated? _____

28, a. How often do you have headaches? _____
b. When does this occur? _____
c. How are they treated? _____

29. a. Do you have vision problems? (Please specify)_____
b. Approximate date of last examination _____

30. a. Do you have hearing problems? (Please specify)_____
b. Approximate date of last examination _____

31. a. Did you have a history of frequent ear infections? _____
b. How often? _____c. When? _____
d. Treatment _____

32. a. Has presenting problem (see #1) been treated medically in the past? _____
b. Describe medication(s) _____
c. What changes, if any, did you notice? _____
(please use additional space for complete history)

33. a. List medications you currently take: _____
b. Prescribing physician's name, address and phone number: _____
_____
c. When medication started: _____ d. Dosage_____

Developmental History

34. a. As an infant, were you fussy? _____
b. Over-sleepy/difficult to rouse? _____
c. Did child respond to cuddling? _____

35. Compared to other children, did you have difficulty learning:
a. To understand language? _____ Please describe: _____
_____
b. To talk? _____ Please describe: _____

_____

c. Gross motor skills (walking, hopping, riding bicycle, etc.)? _____
Please describe: _____
d. Fine motor skills (fastening buttons, zippers, tying shoelaces, drawing, etc.?) Please describe: _____
_____
e. Early school-related skills (naming colors, saying alphabet, recognizing coins, etc.)?
_____
Please describe: _____
f. To play/socialize with other children? _____
Please describe: _____
_____
g. To build with blocks, play with puzzles, draw pictures? _____
Please describe: _____
g. To sit still for television or stories? _____Please describe:_____

36. a. Did you have difficulty leaving parents as a child?
_____
b. At what age?_____

37. a. When were you toilet trained for a day?_____ b. For night?
_____

38. a. Have you had any sleeping difficulties?_____
b. Eating difficulties? _____

39. a. At what age did you show a clear hand preference? _____
b. Which hand was preferred? _____

40. a. Do you relate better with older, younger, or same age peers? _____
b. Do you have opportunity to relate with many peers? _____

41. a. Have you ever had psychotherapy or counseling? _____
b. When? _____ c. With whom? _____
d. How often? _____ e. How long? _____
f. Was it useful? _____
Please describe: _____
_____
(use back of this page for more room)
g. May we contact therapist/counselor? _____
If yes to 41g, please sign Release form.

Testing History

42. Please rank your self-esteem (self-confidence) in the following areas (1 is low – 5 high):

a.	Academic	(low)	1	2	3	4	5 (high)
b.	Social		1	2	3	4	5

c.	Athletic	1	2	3	4	5
d.	Family	1	2	3	4	5
e.	Work	1	2	3	4	5

Have there been any major changes in these areas? _____
When? _____ Please describe _____
(use additional space, if needed)

43. a. Have you had prior independent (outside school) evaluations?_____
b. When?_____
c. Where? _____
d. What type?_____

44. a. Have you ever been evaluated under the provisions of Massachusetts Chapter 766 (CORE)?_____ b. How many times? _____
c. Date of most recent evaluation: _____
d. What type(s) of evaluation(s) (e.g. speech and language, reading, etc):
Please check: Educational Psychological Speech & Language
Reading PT/PT Home Visit
Neurological Other_____

School History

45. a. Have you ever repeated a grade? _____ b. Which grade? _____

46. What schooling (if any) did you have before first grade? (Please specify)_____
_____

47. In what grade did school problems become noticeable? _____

48. a.What specific educational intervention plans have been made in the past?
_____
_____
_____
b. Type(s) of specialist(s) _____
c. How often? _____ d. For how long? _____

49. Have you had recent changes of school program or work? If so, please describe:
_____
_____

50. a. How many schools have you attended/jobs have you had?

b. Please list (include grade/type of employment):

51. Full address for your present school or work:

Name of school/work _____
Street_____
City _____ State _____ Zip_____

52. a.Who is appropriate contact person for details of your schoolwork or employment?
_____
_____

b. May the clinician call this person to ask about your work, etc.? _____
c. May we send our school/work questionnaire? _____
d. Are there other school or work personnel whom we should contact? If so, please specify:
_____
e. Your consenting signature for questions 52b, c, and d _____

_____
Your Signature

_____
Street Address

_____
City State Zip

_____
Phone No.

Date _____