THE spectrum CENTER LLC.

Testing and Counseling services for the autism, gender, ADHD and learning diversity spectrums

1930 Marlton Pike East, Suite J-49, Cherry Hill, NJ 08003 | 856.313.5619 (ph/txt) • 888.496.4170 (fax) | TKoser@SJSpectrumCenter.com

For psychologist use only
Date: _____ Start Time: _____ End time: _____

Demographics and contact information:

Name: _____ Gender/Pronouns: _____

Date of Birth: _____ Age: _____

Current College year (if applicable) _____

How do you describe your racial background: _____

What languages does your family speak: _____

Home phone number: _____ Address: _____

Cell phone number: _____ _____

Email: _____ _____

Preferred contact: (circle) Home Cell Email May I leave a message on your v-mail? YES NO

Marital Status: ___Married ____Widowed ____Separated ____Divorced ____Never Married

Spouse Name (if applicable): _____

Emergency contact: _____ Relationship to you: _____

Home phone number: _____ Address: _____

Cell phone number: _____ _____

Email: _____ _____

ALLERGIES:

Medication: _____

Food: _____

Environmental/seasonal: _____

Primary Doctor: _____ Dr. Address: _____

Dr. Phone #:_____ _____

_____

Specialist1: _____ Specialist's Address: _____

Specialist's Phone #: _____ _____

Hospital/clinic association: _____ _____

Specialist2: _____ Specialist's Address: _____

Specialist's Phone #: _____ _____

Hospital/clinic association: _____ _____

What are you seeking help for? **?**_____

_____

_____

What are your strengths? What are you good at: _____

_____

_____

Chief Concern(s) *(check any that apply)*

____ Learning problems with reading
____ Learning problems with math
____ Completion of work/school assignments
____ Failing grades/poor academic performance
____ Aggressive Behavior
____ Getting along with family members
____ Getting along with others
____ Anger problems
____ Depression
____ Low self-esteem
____ Anxiety
____ Comprehending things said to you
____ Saying what you want to say
____ Mood swings/variability
____ Sleeping difficulties
____ Eating difficulties
____ Substance use/abuse
____ Smoking
____ Harm another person
____ Social differences or autism/Asperger's
____ Intense Fears or phobias (Please explain): _____

_____

____ Attention Difficulties (Please explain): _____

_____

____ Significant change in behavior (Please explain): _____

_____

Other: _____

_____

Risk factors: *(check any that apply)*

____History of self-injurious behavior (Describe) _____

_____

___Previous suicide attempt/thoughts (Describe)_____

_____

___Current suicidal thoughts or urges (Describe) _____

_____

___ Any sexual behavior placing you at risk for legal or personal consequences(Describe) _____

_____

___ Any guns or other weapons in the home or other places you spend time? How are they secured?

_____

Social and Family History

Do You Live: Alone?_____ With Partner/Spouse_____ With Roommate____ With Family? _____

List Your Family Members

Name	**Age**	**Living at Home?**	**School/Grade or Occupation**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List others living with you: _____

_____

Do you make friends easily? _____

Do you have many friends? _____

Do you have trouble keeping Friends? No Yes: Why: _____

Have there been any upsetting events at home? No Yes: Explain_____

_____

or with friends? No Yes: Explain _____

_____

Religious Affiliation/Spirituality Relevance to presenting problem(s)

Your and/or family spiritual/religious tradition(s): _____ □ Resource □ Stressor
Local religious affiliation (church, synagogue, etc): _____ □ Resource □ Stressor

Cultural beliefs/needs to be considered (ex: dietary restrictions): _____

Spiritual resources desired (ex: Mass, specific prayer times, etc): _____

Medical History

Prenatal & Neonatal History (complete only if confirmed by Dr. Koser):

You mother's health during the pregnancy: Excellent _____ Good _____ Fair _____ Poor_____

Any illnesses or complications during the pregnancy? (Explain) _____

_____

List any prenatal exposure to alcohol/street drugs/nicotine: _____

_____

Length of Pregnancy: _____ weeks Labor: _____hours
Type of Delivery: Vaginal _____ Cesarean_____

Birthweight: _____pounds _____ ounces Breech presentation? _____

Complications (if any): _____

_____

Condition at birth: _____

NICU care?: No Yes: length of stay:_____ Jaundiced? No Yes: light therapy - No Yes

Oxygen needed? No Yes Incubator? No Yes Transfusion Needed? No Yes

Length of hospital stay: Infant: _____days Mother: _____days

Medication Name	Current	Past	Daily Dose	Ages of Treatment	Effects

Medication Name	Current	Past	Daily Dose	Ages of Treatment	Effects

Please check all the illnesses/conditions that you have had:

_____ Asthma
_____ Ear Infection #:___
_____ Convulsions/Seizures
_____ Encopresis (Bowel problems)
_____ Enuresis (bed/pants wetting)
_____ Diabetes
_____ Lead level concern
_____ Loss of Consciousness
_____ Head injury/Concussions
_____ Headaches
_____ Body aches
_____ Sexually Transmitted Infections, specify: _____
_____ Epilepsy
_____ Ear/hearing problem
_____ Meningitis
_____ Stomachaches
_____ GI problems

Please explain any areas checked above in detail _____

_____

_____

_____

Date of last vision screen? _____ Date of last hearing screen?_____

Other serious illness or injury? (Describe): _____

_____

_____

Any hospitalizations? No __ Yes____ When? _____

What for? _____

Any surgeries? No __ Yes____ When? _____

What for? _____

How is your sleep: *(circle one)* Regularly or Irregularly , explain: _____

_____

Do you have any concerns or problems with eating: *(circle one)* Regularly or Irregularly, explain: _____

_____

Have you had any Labs, x-rays, genetic testing, or other special tests? _____

_____

_____

Family Medical History

Any relatives with special needs like autism or intellectual disability/MR? _____

_____

Any family members with congenital abnormalities/birth defects? _____

_____

Any deaths within the immediate family (including infants)? _____

_____

List any mental health problems within the family. _____

_____

List any family members with alcohol and/or other substance abuse issues. _____

_____

Describe any other medical problems within the family that are worrying you or need you special attention.

_____

_____

Behavioral Health Treatment History:

□None
□ Out-Patient Psychotherapy
□ Out-Patient Medication Management
□ Behavioral Health Rehabilitation Services (aka "Wrap-around)
□ School-Based Behavioral Health Services
□Partial Hospitalization (approximate # _____ of days)
□ Inpatient Hospitalization
□ Residential Treatment Facility

Dates	**Provider/Agency**	**Reason**	**Outcome**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If currently in outpatient treatment please identify provider, frequency, date last seen and main focus for services: _____

_____

_____

_____

Substance Use History

Substance	Current Use (Y or N)	Date of Last Use	Freq. of Use	Typical amount used

For any substance listed above not currently used, why did you stop using? _____

_____

Problems related to substance use:
____ Interpersonal/family ____ Work ____ School ____ Legal

Please describe any problems noted above: _____

_____

_____

Past treatment for substance use (including 12 step programs)

Provider	Approximate Dates	Outcome

Abuse History:

Have you or and close family been the victim of a violent crime? YES NO

If Yes, please describe: _____

_____

Have you experienced any of the following?:
Physical abuse ____Yes ___No
Emotional abuse ____Yes ___No
Sexual abuse ____Yes ___No
Bullying ____Yes ___No
Any other frightening event (fire, accident, natural disaster, serious injury? ____Yes ___No

If yes to any of the above, please describe the nature, intensity and impact of the abuse: _____

_____

_____

_____

Educational History:

Highest Grade/Degree Completed to date: _____

Degrees Completed:

School	Diploma/Degree	Date Completed

Did you have any previous developmental or educational testing when younger? No or Yes: _____

_____

Current Educational Setting (if applicable – skip to work section below if no longer in school/college):

School: _____ Location: _____

Year/Status: _____

How are you doing academically? _____

_____

Explain any current school problem(s) and any previous difficulties: _____

_____

_____

Have you been expelled from or asked to leave any school placement? No Yes, why_____

_____

_____

Work/Career History:

Past jobs:

Position/title	Type of work	Approximate dates

Current work:

Employer: _____ Location: _____

Title/position: _____ Employed since: _____

Type of work and general responsibilities: _____

_____

Do you have any concerns about work related to this evaluation: No Yes, why _____

_____

Explain any current work problem(s) and any previous difficulties: _____

_____

_____

Have you been fired or asked to resign from a job? No Yes, why_____

_____

_____

ANY OTHER IMPORTANT INFORMATION: _____

_____

_____

_____

_____