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Diplomate of the American Board of Psychiatry and Neurology

Child, Adolescent & Adult Psychiatry

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Adult Psychological History

Date of Appointment: ______________________

Name of person filling out form:____________________________________ Relationship to patient:__________________

Patient Name: ______________________________________ Sex: ______ Age: _____ Date of Birth: ______________

Social Security #:__________________________ Home Address: ____

Home Phone:________________________ Work Phone:______________________ Cell Phone:__________________

Email:____ Employer:____

Referred By: ______________________________ Reason For Referral:______________________________________

Litigation pending?________ Attorney: _________________________________ Phone: ___________________________

History of Present Problem

How long ago did problems begin: ______________________________

Please describe the problems that you want help with:____

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Psychiatric History

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Current	Past		Current	Past	
☐	☐	Suicidal thoughts (date?______________)	☐	☐	Homicidal thoughts (date?_______________)
☐	☐	Depression/sadness	☐	☐	Anxiety/nervousness
☐	☐	Difficulty sleeping	☐	☐	Nightmares
☐	☐	Overeating	☐	☐	Loss of appetite
☐	☐	Weight gain	☐	☐	Weight loss
☐	☐	Visual/auditory hallucinations	☐	☐	Sexual Problems
☐	☐	Anorexia/Bulimia	☐	☐	Apathy
☐	☐	Rapid mood changes	☐	☐	Explosive anger
☐	☐	Decreased need for sleep	☐	☐	Euphoria (feel on top of the world)
☐	☐	Distractible	☐	☐	Racing thoughts
☐	☐	Fatigue	☐	☐	Feeling worthless
☐	☐	Poor self-esteem	☐	☐	Loss of interest in almost all activities
☐	☐	Overwhelming need to perform certain	☐	☐	Recurrent/intrusive disturbing
☐	☐	Behaviors/rituals			recollections/dreams
☐	☐	Significant concerns with physical problems	☐	☐	Excessive fears or phobias

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
☐	☐	Death of spouse	☐	☐	Death of family member	☐	☐	Illness of family member
☐	☐	Illness of friend	☐	☐	Personal injury/illness	☐	☐	Marital difficulties
☐	☐	Marital separation	☐	☐	Divorce	☐	☐	Sexual Difficulties
☐	☐	Conflicts with family	☐	☐	Conflicts with friends	☐	☐	Conflicts at work
☐	☐	New Job	☐	☐	Job termination	☐	☐	Retirement
☐	☐	Business difficulties	☐	☐	Academic difficulties	☐	☐	Financial problems
☐	☐	Change in residence	☐	☐	Legal problems	☐	☐	Sexual assault
☐	☐	Incent/sexual abuse	☐	☐	Physical abuse	☐	☐	Verbal/emotional abuse
☐	☐	Other problems: ______________________________						

Are you currently receiving therapy? ☐ Yes ☐ No From who?____________________________
When did you start therapy?________________________For what problems(s)?____________________________
____
List current psychiatric medications:____
Have you received therapy in the past? ☐ Yes ☐ No From who?____________________________
When (Start and finish):_____________________________For what problem(s)?____________________________
____
List past psychiatric medications:____
Have you been hospitalized for psychological problems? ☐ Yes ☐ No When?____________________________
Where were you hospitalized?____
Have you ever attempted suicide? ☐ Yes ☐ No When?____________________How?____________________

Have you had a prior psychological or neuropsychological evaluation? ☐ Yes ☐ No If yes, complete this information:
Name of psychologist: ____
Address: ____
Phone:_________________________________ Date of and reason for this evaluation:______________________________
Findings of the evaluation: ____

Substance Use History

Current Past (Even if only occasionally or in small amounts):

☐ ☐ Alcohol What do you drink? ☐Beer ☐Wine ☐Mixed Drink ☐ Hard Liquor
How Often? ___________ How Many? _________
DUI? ☐ Yes ☐ No Accidents? ☐ Yes ☐ No Missed work or school? ☐ Yes ☐ No
Risky Behavior ☐ Yes ☐ No If so, what? ________________________________

☐ ☐ Tobacco How Much? _____________ How Often? __________ When did you quit? ____________

☐ ☐ Marijuana

☐ ☐ Barbiturates ("Downers")

☐ ☐ Tranquilizers

☐ ☐ Amphetamines ("Speed")

☐ ☐ Crank

☐ ☐ Crack

☐ ☐ Cocaine

☐ ☐ Opiates (Heroine, Opium, Codeine, etc.)

☐ ☐ Hallucinogenic (LSD, STP, "Magic Mushrooms", etc.)

☐ ☐ PCP ("angel dust")

☐ ☐ Ecstasy

☐ ☐ Other: _________________________________

DOCTOR'S NOTES

Birth and Developmental History (The patient's)

Place of Birth:____ Were parents married at time of birth? ________________
Was mother under a doctor's care during the pregnancy? _________ Were you adopted? ________ If so, at what age? _______

Check any illnesses during pregnancy:
☐ Anemia ☐ Toxemia ☐ Herpes ☐ Measles ☐ German measles ☐ Bleeding
☐ Kidney disease ☐ Heart disease ☐ Hypertension ☐ Abdominal trauma ☐ Infection ☐ Diabetes

Medications taken during pregnancy:____
Were drugs or alcohol taken during pregnancy? ☐ Yes ☐ No If yes, specify:______________________________________
Was there significant emotional stress during pregnancy? ☐ Yes ☐ No If yes, name stressors: _______________________

Was the birth: ☐ On time ☐ Premature (By how long: ________________) ☐ Late (By how long: _____________________)
Was labor: ☐Spontaneous ☐ Induced Duration of labor ______(Hours) ☐ Cesarean required ☐ Cesarean planned
Was the presentation: ☐ Normal ☐ Breach ☐ Transverse (Crosswise) ☐ Posterior first
Did the baby experience any of these problems: ☐ Fetal distress ☐ Prolapsed cord ☐ Low placenta (Placenta previa)
☐ Premature separation of the placenta (Abruptio placenta) ☐ Cord wrapped around neck
Any other problems that mother or child had: ____
Was general anesthesia used: ☐ Yes ☐ No Were forceps used? ☐ Yes ☐ No Breathing problems? ☐ Yes ☐ No
Color at birth: ☐ Normal ☐ Blue ☐ Yellow Was oxygen used? ☐ Yes ☐ No (How long)? _______
APGAR Score: __________ Birthweight: __________ Length: _____________

Check those that apply to the first few weeks after birth:
☐ Excessive sleeping ☐ Laziness ☐ Irritability ☐ Excessive crying ☐ Stiffness ☐ Limpness ☐ Tremors
☐ Twitching ☐ Feeding difficulties ☐ Vomiting ☐ Jaundice Other:_______________

Transfusions required? ☐Yes ☐No Medication required? ☐Yes ☐No (Why) ________________________________
Surgery required? ☐Yes ☐No (Why) ____

Give approximate ages that developmental milestones were achieved:
Head control _________ Rolled over _________ Sat alone _________ Walked _________ Run ________
Said first word _______ Used sentences __________ Self feeding w/ utensils _______ Toilet trained _____________
Dress self _________ Tie shoes _________ Color within lines _________ First menstruation or beginning of puberty: ______

Check any problems that occurred in later development:

☐ Hearing ☐ Speaking ☐ Stuttering ☐ Reading ☐ Writing ☐ Spelling ☐ Arithmetic
☐ Behavior ☐ Hyperactivity ☐ Seizures ☐ Coordination ☐ Attention difficulties

List family members with developmental or learning problems: ____

DOCTOR'S NOTES

Medical History

Please check all the conditions that have been diagnosed as a child or an adult.

- ☐ AIDS, ARC or HIV
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Abscessed ears
- ☐ Arteriosclerosis
- ☐ Bleeding disorder
- ☐ Blood disorder
- ☐ Broken bones
- ☐ Brain
- ☐ Cerebral palsy
- ☐ Colds (excessive)
- ☐ Chicken pox
- ☐ Carbon monoxide
- ☐ Cancer
- ☐ Diabetes
- ☐ Enzyme deficiency
- ☐ Encephalitis
- ☐ Ear Infections
- ☐ Fevers (104 or higher)
- ☐ Genetic disorder
- ☐ Head injury
- ☐ Heart problems
- ☐ Hereditary disorder
- ☐ Headaches
- ☐ Hearing problems
- ☐ Huntington's disease
- ☐ Hypertension
- ☐ Hormone problems
- ☐ Hazardous Substance
- ☐ Immune system
- ☐ Jaundice
- ☐ Kidney problems
- ☐ Liver disorder
- ☐ Lung disease
- ☐ Lead poisoning
- ☐ Leukemia
- ☐ Metabolic disorder
- ☐ Meningitis
- ☐ Measles
- ☐ Mumps
- ☐ Malnutrition
- ☐ Multiple sclerosis
- ☐ Oxygen deprivation
- ☐ Pneumonia
- ☐ Poisoning
- ☐ Polio
- ☐ Parkinson's disease
- ☐ Rheumatic Fever
- ☐ Radiation Exposure/Therapy
- ☐ Scarlet Fever
- ☐ Senility (Dementia)
- ☐ Stroke or TIA
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Thyroid disease
- ☐ Venereal disease
- ☐ Vision problems
- ☐ Whooping cough
- ☐ Other medical/physical ____________________

Have you ever been diagnosed with epilepsy or a seizure disorder? ☐ Yes ☐ No If yes, check the one you have been diagnosed with.

PARTIAL
- ☐ Simple partial
- ☐ Complex partial
- ☐ Partial evolving into generalized

GENERALIZED
- ☐ Absence (Petit mal)
- ☐ Myonclonic
- ☐ Clonic
- ☐ Tonic
- ☐ Tonic-clonic (Grand mal)
- ☐ Atonic

☐ UNCLASSIFIED

Medication and dosage:

List any medications currently being taken (over-the-counter or prescription), and the dosage

1) ____________________
2) ____________________
3) ____________________
4) ____________________
5) ____________________
6) ____________________

List any medications you are ALLERGIC or sensitive to: ____________________

Past Hospitalizations (When, where and for what):

____

Outpatient Surgeries (When, where and for what):

____

Name of family physician: ____________________
Address: ____________________
Phone: ____________________ Date of your last medical check-up: ____________________

Medical Testing

Check all medical tests that recently have been done and report any abnormal findings:

Test	Check here if normal	Abnormal findings
☐ Angiography	☐	______
☐ Blood work	☐	______
☐ Brain scan	☐	______
☐ CT scan	☐	______
☐ EEG	☐	______
☐ Lumbar puncture or spinal tap	☐	______
☐ Magnetic Resonance Imaging (MRI)	☐	______
☐ Neurological office exam	☐	______
☐ PET scan	☐	______
☐ Physician's office exam	☐	______
☐ Skull x-ray	☐	______
☐ Ultrasound	☐	______
☐ Other testing:______	☐	______

DOCTOR'S NOTES

Family History

Father's Name ________________________________ Age _______ Health Problems ___________________________
Education ___________ Occupation ________________________ Employer ___________________________________
Mother's Name ________________________________ Age _______ Health Problems ___________________________
Education ___________ Occupation ________________________ Employer ___________________________________
Date of parent's marriage ____________ Years married _______ Current marital problems? _________________________
If separated, give date _______________ If divorced, date _______________________
Previous marriages? (Father) _________ (Mother) _________Subsequent marriages? (Father) _________(Mother) _________
If divorced, current custody arrangement ____

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years

Names and ages of brothers and sisters (Include step-brothers and step-sisters):
____
____
____
____

List anyone else who lived in the home during your childhood: ______________________________________

List names of any biologically related family members (E.G. Immediate and distant relatives) with any of the following problems:
Alcohol Abuse ____
Criminal History: ____
Psychological/behavior problems: ____
Medical problems (e.g. Heart disease, Cancer, Seizures) ____
Learning/developmental problems: ____

DOCTOR'S NOTES

Marital History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Current Marriage

Date of marriage:__________ Number of years married: ______ Date of separation:____________ Date of divorce:______
Spouse's name: ______________________________ Age:______ Health:______________________
Education: ______ Occupation: ______________________________ Type of marital problems: ______________
Names and ages of children: ____
If divorced/separated, what is the custody arrangement: ____

Prior Marriage

Date of marriage:__________ Number of years married: ______ Date of separation:____________ Date of divorce:______
Spouse's name: ______________________________ Age:______ Health:______________________
Education: ______ Occupation: ______________________________ Type of marital problems: ______________
Names and ages of children: ____
If divorced/separated, what is the custody arrangement: ____

Prior Marriage

Date of marriage:__________ Number of years married: ______ Date of separation:____________ Date of divorce:______
Spouse's name: ______________________________ Age:______ Health:______________________
Education: ______ Occupation: ______________________________ Type of marital problems: ______________
Names and ages of children: ____
If divorced/separated, what is the custody arrangement: ____

List any other marriages and children:

____
____

List names of spouses or children with the following problems:
Developmental Learning Problems: ____
Emotional/Behavioral problems: ____
Alcohol/Drug abuse: ____
Medical Problems: ____

DOCTOR'S NOTES

Social History

If single or separated, are you currently dating anyone? ___________How long? ________Is it a serious relationship? _________
First name: _______________ Are you currently sexually active? _________ If not dating, when was your last date? _________
How long did you date that person? ___________Was it a serious relationship? _________First name: _____________________

Please list "significant others" you have lived with but not married.

Current/Most Recent Cohabitation

Date began:________________________ Number of years together:___________________ Date ended:__________________
Name :____ Age:___________ Health: ___________________________
Education: _______ Occupation: _____________________________________ Type of relationship problems: _______________
Names and ages of children: ____
If separated, what is the custody arrangement: ____

Prior Cohabitation

Date began:________________________ Number of years together:___________________ Date ended:__________________
Name :____ Age:___________ Health: ___________________________
Education: _______ Occupation: _____________________________________ Type of relationship problems: _______________
Names and ages of children: ____
If separated, what is the custody arrangement: ____

Have you lived with anyone else in the past? ☐Yes ☐No How many times?_____________________________________
Any other children outside of marriage? ☐Yes ☐No Names/Ages: ____
Any aborted pregnancies/miscarriages? ☐Yes ☐No When? ____

List clubs and community business organizations you are involved with and how often you attend: ______________________
____
Do you attend church? ☐Yes ☐No (where and how often) : ____
What do you do with your free time (including hobbies and extracurricular interests): _____________________________________
When was your last vacation (Please describe): ____
How many close friends do you have in the community: _________How often do you get together with friends or family: ________
How long have you lived in the community: ____________ Where have you lived in the past: _____________________________

DOCTOR'S NOTES

Educational History

Current grade (Or highest grade/degree completed): _________ Current school: ____________________
Past schools attended (List in order): ____________________
Hardest subject(s): ____________________ Favorite subject(s): ____________________
Grades in elementary school: __________ Junior High G.P.A. __________ High School GPA _________ College GPA ________
Grades repeated: ________________ Learning problems (what subjects): ____________________
Special education placement (Type): _________ During which grades: ____________________
Extracurricular activities (Music, Sports, Clubs, etc.) ____________________
Expulsions/suspensions/conduct problems (Type of problem and date): ____________________
Additional schooling or non-academic training: ____________________

DOCTOR'S NOTES

Occupational History

Present employer: ____________________ Position: ____________________
Length of employment: _________ Hours worked per week __________ Current responsibilities: ____________________

List previous employment for last ten years (Include dates and type of work):____________________
____

Have you ever been terminated from a job (Please explain):____________________
At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)? ☐Yes ☐No If yes, explain: ____________________
Have you ever been injured on the job? ☐Yes ☐No If yes, explain: ____________________

DOCTOR'S NOTES

Legal History

☐ Not Applicable

Present legal problems (Describe): ____________________
Past arrests (For what?): ____________________
Convictions (For what?): ____________________
Time served in juvenile hall, jail or prison (Give dates and locations): ____________________

DOCTOR'S NOTES

Military Service

☐ Not Applicable

Branch of service: ____________ Dates of service: ____________ Job(s) within service: ____________
Highest rank: ____________ Rank at discharge: ____________ Discharge status: ____________
Were you exposed to any dangerous or unusual substances (e.g. Agent Orange, Radiation, etc.) ☐Yes ☐No
If yes, explain: ____________________
Did you sustain any physical injuries in the military? ☐Yes ☐No If yes, explain: ____________________

DOCTOR'S NOTES

Adult General System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, please have another person who knows you well (such as a spouse or roommate) rate you also to help provide a complete picture of you. Name of other person: ____

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Self	Other	Descriptor		
___	___	Depressed or sad mood		
___	___	Decreased interest in things that are usually fun, including sex		
___	___	Significant **recent** weight gain or loss, or marked appetite changes, increased or decreased		
___	___	Recurrent thoughts of death or suicide		
___	___	Sleep changes, lack of sleep or marked increase in sleep		
___	___	Physically agitated or “slowed down”		
___	___	Low energy or feelings of tiredness		
___	___	Feelings of worthlessness, helplessness, or guilt		
___	___	Decreased concentration or memory	MD	5
___	___	Periods of an elevated, high or irritable mood		
___	___	Periods of a very high self-esteem or grandiose thinking		
___	___	Periods of decreased need for sleep **without** feeling tired		
___	___	More talkative **than usual** or pressure to keep talking		
___	___	Fast thoughts or frequent jumping from one subject to another		
___	___	Easily distracted by irrelevant things		
___	___	Marked increase in activity level		
___	___	Excessive involvement in pleasurable activities which have the potential for painful consequences (spending Money, sexual indiscretions, gambling, foolish business ventures)	BD	4
___	___	Panic attacks, which are periods of intense, unexpected fear or emotional discomfort (#/mo____)		
___	___	Periods of trouble breathing or feeling smothered		
___	___	Periods of feeling dizzy, faint or unsteady on your feet		
___	___	Periods of heart pounding or rapid heart rate		
___	___	Periods of sweating		
___	___	Periods of choking		
___	___	Periods of nausea or abdominal upset		
___	___	Feelings of a situation “not being real”		
___	___	Numbness or tingling sensations		
___	___	Hot or cold flashes		
___	___	Periods of chest pain or discomfort		
___	___	Intense fear of dying		
___	___	Fear of going crazy or doing something uncontrolled	PD	18, 4
___	___	Avoiding everyday places for fear of having a panic attack or needing to go with other people in order to feel comfortable		
___	___	Excessive fear of being judged by others which causes you to avoid or get anxious in situations		
___	___	Persistent, excessive fear of ☐ heights ☐ closed spaces ☐ specific animals ☐ other: _______________		

Adult General System Checklist

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Self	Other	Descriptor		
___	___	Recurrent bothersome thoughts, ideas or images which you try to ignore		
___	___	Trouble getting “stuck” on certain thoughts, or having the same thought over and over		
___	___	Excessive or senseless worrying		
___	___	Others complain that you worry too much or get “stuck” on the same thoughts		
___	___	Compulsive behaviors that you must do or you become very anxious such as excessive hand washing, Checking locks, or counting or spelling		
___	___	Needing to have things done a certain way or you become very upset		
___	___	Others complain that you do the same thing over and over to an excessive degree (e.g. cleaning or checking	OC	3
___	___	Recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.)Please list: ________		
___	___	Recurrent distressing dreams of a past event		
___	___	A sense of reliving a past upsetting event		
___	___	A sense of panic or fear to events that resemble an upsetting past event		1
___	___	You spend effort avoiding thoughts or feelings associated with a past trauma		
___	___	Persistent avoidance of activities/situations which cause remembrance of upsetting event		
___	___	Inability to recall an important aspect of a past upsetting event		
___	___	Marked decreased interest in important activities		
___	___	Feeling detached or distant from others		
___	___	Feeling numb or restricted in your feelings		
___	___	Feels that your future is shortened		3
___	___	Startles easily		
___	___	Feels like you are always watching for bad things to happen		
___	___	Marked physical response to events that remind you of a past upsetting event (i.e. sweating when getting In a car if you had been in a car accident)	PTS	2
___	___	Trembling, twitching or feeling shaky		
___	___	Muscle tension, aches or soreness		
___	___	Feelings of restlessness		
___	___	Easily fatigued		
___	___	Shortness of breath or feeling smothered		
___	___	Heart pounding or racing		
___	___	Sweating or cold clammy hands		
___	___	Dry mouth		
___	___	Dizziness or lightheadedness		
___	___	Nausea, diarrhea or other abdominal distress		
___	___	Hot or cold flashes		
___	___	Frequent urination		
___	___	Trouble swallowing or “lump in throat”		
___	___	Feeling keyed up or on edge		
___	___	Quick startle response of feeling jumpy		
___	___	Difficulty concentrating or “mind going blank”		
___	___	Trouble falling or staying asleep		
___	___	Irritability	GAD	6

Adult General System Checklist

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Self	Other	Descriptor	
___	___	Trouble sustaining attention or being easily distracted	
___	___	Difficulty completing projects	
___	___	Feeling overwhelmed of the tasks of everyday living	
___	___	Trouble maintaining an organized work or living area	
___	___	Inconsistent work performance	
___	___	Lacks attention to detail	
___	___	Makes decisions impulsively	
___	___	Difficulty delaying what you want, having to have your needs met immediately	
___	___	Restless, fidgety	
___	___	Make comments to others without considering their impact	
___	___	Impatient, easily frustrated	
___	___	Frequent traffic violations or near accidents	AAD 5
___	___	Refusal to maintain body weight above a level most people consider healthy	
___	___	Intense fear of gaining weight or becoming fat even though underweight	
___	___	Feelings of being fat, even though underweight	AN 3
___	___	Recurrent episodes of binge eating large amounts of food	
___	___	A lack of control over eating behavior	
___	___	Engage in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise	
___	___	Persistent over concern with body shape and weight	BN 2
___	___	Involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking) How long have motor tics been present? _______ How often? ___________________________________ Describe: ____	
___	___	Involuntary vocal sounds or verbal tics (such as coughing, puffing, whistling, swearing) How long have motor tics been present?_____ How often?_______ Describe:____	
___	___	Delusional or bizarre thoughts (thoughts you know others would think are false)	
___	___	Seeing objects, shadows or movements that are not real	
___	___	Hearing voices or sounds that are not real	
___	___	Periods of time where your thoughts or speech were disjointed or didn't make sense to you or others	
___	___	Social isolation or withdrawal	
___	___	Severely impaired ability to function at home or at work	
___	___	Peculiar behaviors	
___	___	Lack of personal hygiene or grooming	
___	___	Inappropriate mood for the situation (i.e., laughing at sad events)	
___	___	Marked lack of initiative	PsD 3
___	___	Frequent feelings that someone or something is out to hurt you or discredit you	
___	___	Do you snore loudly (or do others complain about your snoring)	
___	___	Have others said you stop breathing when you sleep	
___	___	Do you feel fatigued or tied during the day	SA

Adult General System Checklist

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known

Self	Other	Descriptor		
___	___	Do you often feel cold when others feel fine or they are warm		
___	___	Do you often feel warm when others feel fine or they are cold		
___	___	Do you have problems with brittle or dry hair		
___	___	Do you have problems with dry skin		
___	___	Do you have problems with sweating		
___	___	Do you have problems with chronic anxiety or tension	ThyA	2

___ ___ Impairment in communication as manifested by at least one of the following: (check those that apply)

- ☐ Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime
- ☐ In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- ☐ Repetitive use of language or add language
- ☐ Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

___ ___ Impairment in social interaction with at least two of the following (Check those that apply)

- ☐ Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interactions
- ☐ Failure to develop peer relationships appropriate to developmental level
- ☐ Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- ☐ Lack of social or emotional reciprocity

___ ___ Repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following (Check those that apply)

- ☐ Preoccupation with an area that is abnormal either in intensity or focus
- ☐ Rigid adherence to specific, nonfunctional routines or rituals
- ☐ Repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- ☐ Persistent preoccupation with parts of objects

Adult Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, please have another person who knows you well (such as a spouse or roommate) rate you also to help provide a complete picture of you. Name of other person: ___________________________________

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Self	Other	Descriptor		
___	___	Fails to give close attention to details or makes careless mistakes		
___	___	Trouble sustaining attention in routine situations (i.e. homework, chores, paperwork)		
___	___	Trouble listening		
___	___	Fails to finish things		
___	___	Poor organization for time or space (such as backpack, room, desk, paperwork)		
___	___	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort		
___	___	Loses things		
___	___	Easily distracted		
___	___	Forgetful		
___	___	Poor planning skills		
___	___	Lack clear goals or forward thinking		
___	___	Difficulty expressing feelings		
___	___	Difficulty expressing empathy for others		
___	___	Excessive daydreaming		
___	___	Feeling bored		
___	___	Feeling apathetic or unmotivated		
___	___	Feeling tired, sluggish or slow moving		
___	___	Feeling spacey or "in a fog"		8,6,4
___	___	Fidgety, restless or trouble sitting still		
___	___	Difficulty remaining seated in situations where remaining seated is expected		
___	___	Runs about or climbs excessively in situations in which it is inappropriate		
___	___	Difficulty playing quietly		
___	___	"On the go" or acts as if "driven by a motor"		
___	___	Talks excessively		
___	___	Blurts out answers before questions have been completed		
___	___	Difficulty waiting turn		
___	___	Interrupts or intrudes on others (e.g. butts into conversations or games)		
___	___	Impulsive (saying or doing things without thinking first	<3	8,6,4
___	___	Excessive or senseless worrying		
___	___	Upset when things do not go your way		
___	___	Upset when things are out of place		
___	___	Tendency to be oppositional or argumentative		
___	___	Tendency to have repetitive negative thoughts		
___	___	Tendency toward compulsive behaviors		
___	___	Intense dislike for change		
___	___	Tendency to hold grudges		
___	___	Trouble shifting attention from subject to subject		
___	___	Trouble shifting behavior from task to task		
___	___	Difficulty seeing options in situations		
___	___	Tendency to hold on to own opinion and not listen to others		
___	___	Tendency to get locked into a course of action, whether or not it is good		
___	___	Needing to have things done a certain way or you become very upset		
___	___	Others complain that you worry too much		
___	___	Tend to say no without first thinking about question		

___	___	Tendency to predict fear	ACG	10, 7, 4

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known

Self	Other	Descriptor		
___	___	Frequent feelings of sadness		
___	___	Moodiness		
___	___	Negativity		
___	___	Low energy		
___	___	Irritability		
___	___	Decreased interest in others		
___	___	Decreased interest in things that are usually fun or pleasurable		
___	___	Feelings of hopelessness about the future		
___	___	Feelings of helplessness or powerlessness		
___	___	Feeling dissatisfied or bored		
___	___	Excessive guilt		
___	___	Suicidal feelings		
___	___	Crying spells		
___	___	Lowered interest in things usually considered fun		
___	___	Sleep changes (too much or too little)		
___	___	Appetite changes (too much or too little)		
___	___	Chronic low self-esteem		
___	___	Negative sensitivity to smells / odors	DLS	10,7,4

___	___	Frequent feelings of nervousness or anxiety		
___	___	Panic attacks		
___	___	Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)		
___	___	Periods of heart pounding, rapid heart rate or chest pain		
___	___	Periods of trouble breathing or feeling smothered		
___	___	Periods of feeling dizzy, faint or unsteady on their feet		
___	___	Periods of nausea or abdominal upset		
___	___	Periods of sweating, hot or cold flashes		
___	___	Tendency to predict the worst		
___	___	Fear of dying or doing something crazy		
___	___	Avoid places for fear of having an anxiety attack		
___	___	Conflict avoidance		
___	___	Excessive fear of being judged or scrutinized by others		
___	___	Persistent phobias		
___	___	Low motivation		
___	___	Excessive motivation		
___	___	Tics (motor or vocal)		
___	___	Poor handwriting		
___	___	Quick startle		
___	___	Tendency to freeze in anxiety provoking situations		
___	___	Lacks confidence in their abilities		
___	___	Seems shy or timid		
___	___	Easily embarrassed		
___	___	Sensitive to criticism		
___	___	Bites fingernails or picks skin	BG	10,7,4

0	1	2	3	4	N/A
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**	**Not Applicable Not Known**

Self	**Other**	**Descriptor**
___	___	Short fuse or periods of extreme irritability
___	___	Periods of rage with little provocation
___	___	Often misinterprets comments as negative when they are not
___	___	Irritability tends to build, then explodes, then recedes, often tired after a rage
___	___	Periods of spaciness or confusion
___	___	Periods of panic and/or fear for no specific reason
___	___	Visual or auditory changes, such as seeing shadows or hearing muffled sounds
___	___	Frequent periods of déjà vu (feelings of being somewhere you have never been)
___	___	Sensitivity or mild paranoia
___	___	Headaches or abdominal pain of uncertain origin
___	___	History of head injury or family history of violence or explosiveness
___	___	Dark thoughts, may involve suicidal or homicidal thoughts
___	___	Periods of forgetfulness or memory problems

TL 8,6,4