SHELTON EVALUATION CENTER
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Questionnaire For Adult Clients

Please complete this form to help in understanding the client referred to us. If extra space is needed, please feel free to attach additional pages for your comments.

Date ________________________

Referred by ____________________

Person(s) filling out this form Client ______ Other ____

I. IDENTIFYING DATA

Client's Name ____ Sex _______ Age _______

Date of Birth ___________________

Client currently lives at ____

at ____
(Address, City, State, Zip code)

______________________________ ________________________ __________________________
(Area Code & Home Phone Number) (Cell phone number) (e-mail address)

II. PURPOSE OF THIS EVALUATION

What questions would you like answered by this evaluation? _________________________________

____

____

The client's strengths include ____

____

____

The client's problem include ____

____

____

III. DEVELOPMENTAL HISTORY

A. Was this client adopted? ____________ If yes, age at time of adoption ___________________

Date of adoption __________________ Location of adoption __________________________

B. Mother's medical history during pregnancy:

1. Was this pregnancy a result of IVF? ____

2. Were there any difficulties during pregnancy? _____________________ If so, please describe:

____

____

3. Were there any medications taken during the pregnancy? __________ If so, what kind?

____

4. Were there any accidents during the pregnancy? ______________________ If so, please describe:

____

5. Were there any emotional pressures during the pregnancy? ______________ If so, please describe:

____

____

IV. EARLY HISTORY FOR THIS CLIENT

Where was this client born?____

Length of pregnancy________________________

Were there any difficulties during labor or delivery? __________ If so, what kind?

____

Was delivery by Cesarean section?____

Weight at birth ________lbs. __________oz.

Was the client healthy at birth? _____________If not, please describe:___________________

____

Did the client require a stay in the NICU? __________ If so, for how long? _______________

Were any medications prescribed in the first year? If so, what was prescribed and why?

____

____

Was the client involved in speech-language therapy and/or OT/PT during the first few years of life? _______ If so, why? ____

____

V. DEVELOPMENTAL HISTORY

Were there any delays in reaching the following milestones?

Walking unattended?____

First words spoken? ____

Talked clearly enough that strangers understood? _______________________________________

VI. MEDICAL HISTORY

Has the client had any serious illnesses? Did this require hospitalization? ___________________

____

____

Does the client have a history of ear infections? __________________________

Were they treated with pressure equalizing tubes? _________________________

Is there a history of seizures? ____

Is there a history of head injury? ___________ Concussion? __________ If so, when?__________

____

Please describe any other medical conditions: ____

____

Describe any serious accidents the client has had: ____

____

Who is the client's primary physician? ____

____

When was the client's last physical examination? ____

What were the results?____

Hearing has/has not been checked:

in doctor's office _________; by an Audiologist _________ Date ______

Results: adequate/inadequate. If inadequate, please explain __________________________________

____

Vision has/has not been checked:

in doctor's office _________; by an ophthalmologist/optometrist _______ Date __________

Results: adequate/inadequate. If inadequate, please explain __________________________________

____

Is the client prescribed any medication? __________ If so, what is prescribed and what dosage?

____

____

Have there been any other medications taken in the last twelve months?_________________________

____

Has the client ever been treated or evaluated by a psychologist, counselor, social worker, psychiatrist, etc.? Explain symptoms, diagnosis(es), any suicidal thoughts or attempts?

____

____

____

What type of prescription meds does the client take? _______________________________________

Tobacco use (type, how much)? ____

Alcohol use (type, how much)? ____

Does the client use any recreational drugs? (marijuana, cocaine) How long since you last used any drugs?

____

____

Are you on a special diet? _____Restrictions ____

VII. FAMILY HISTORY

1. List by name the members of this client's family. Please include parents, full, and half siblings.

Name of Family Member	Relationship to This Client	Age	Highest Year of School Completed	Reading, Writing, Math, Speech/ Language or Attention Problems? If so, which and when?

2. Please note a history of the following difficulties in both immediate or extended family.

Illness/Difficulty	Check if Yes	When Occurred	Relationship to Client (e.g., maternal aunt)
Hospitalization for Emotional Problems			
Bi-Polar Disorder			
Schizophrenia			
Mental Retardation			
Drug Addiction			
Criminal Record			
Depression			
Anxiety			
Speech or Articulation Difficulty			
Reading, Writing, Spelling Problems			
Attention Problems or Hyperactivity			
Autism Spectrum Disorder (Asperger's Syndrome), PDD, NOS			
Cognitive Impairment			

Are your parents still married to one another? Yes _____ Divorced?______ When? ____________

Either remarry? When? Father ____________ Mother ____________

With whom did you live during childhood and adolescence? ________________________________

Any abuse experienced? (physical or sexual) ____

Your marital status: ____

Previous marriages? Yes _____ No_____ Dates of marriages and divorces: __________________

____

VIII. SCHOOL HISTORY

A. List the names of schools attended beginning with kindergarten through high school: Indicate if you repeated a grade or had entry into kindergarten or first grade delayed.

School Name	Client's Age	Grade	City/State	School System (public/private)

B. Post High School

Name of School	Years Attended	GPA	Certificate//License/Diploma Earned	Major

Did you ever fail or repeat a grade? If so, please explain.

____

____

What were your best subjects?

____

What were your most difficult subjects?

____

____

If you quit high school or college before graduating, what were the reasons?

____

____

In school:

Did you finish your work in class? Yes ________ No ________

Did you have trouble paying attention? Yes ________ No ________

Did you have trouble staying in your seat when asked? Yes ________ No ________

Did you have difficulty working independently? Yes ________ No ________

Did you have special help at school? Yes ________ No ________

If so, what type (e.g., special education. tutoring, speech therapy, resource room), when and for how long? Please describe. ____________________

____

____

Homework: Done easily? ____________ With difficulty? ____________

Put off studying until last minute ____________________

Did/do you like school? ____________ Comments ____________________

____

What did/do the teachers think the problem was/is? ____________________

____

____

What did/do the teachers think about your behavior? (e.g., general attitude, response when corrected, relationship with classmates, etc.) ____________________

____

____

Vocational History

Years Employed	Company	Position	Reason for Leaving

IX. BEHAVIOR

Reported Problems Client is Presently Experiencing

Yes or No		Explain
______	Memory/Recall/Retention	____________________
______	Hearing	____________________
______	Word Finding	____________________
______	Reading	____________________
______	Written Expression	____________________
______	Handwriting	____________________
______	Reading Comprehension	____________________
______	Mathematics	____________________
______	Sleep	____________________
______	Appetite	____________________
______	Concentration	____________________
______	Depression	____________________

_______ Mood Changes ____

_______ Anxiety/Nervousness ____

_______ Hallucinations ____

_______ Temper/Impulse Control ____

_______ Coordination ____

_______ Headaches ____

_______ Seizures ____

_______ Interpersonal Relations ____

_______ Other ____

Primary source of income ____

Future goals ____

Have you had or are you still having problems with any of the following during childhood or any other time?

	What Age(s)	How Often
Bullying		
Hair twisting/pulling out hair		
Nail biting		
Peer relationships/social skills		
Excessively focused on specific interests		
Fear of darkness		
Restlessness		
Daydreaming		
Truancy		
Fighting		
Temper tantrums		
Resenting discipline		
Eating issues		
Sensitivity to textures		
Other (please describe)		

As a youth, did you ever have contact with the police or juvenile authorities? If so, please explain.

____

____

Have you or a teacher or a pediatrician ever been concerned about an autism spectrum disorder?

____

____

Leisure Activities/Interpersonal Relationships

What leisure activities do you participate in with your family or others? ____________________

____

Do you have any hobbies or leisure interests? ______________________________________

____

If not married, are you currently dating? ____

Describe how you get along with:

Father ____

Mother ____

Brothers ____

Sisters ____

Spouse ____

Children ____

Others in home ____

What plans do you have for changes in such areas as family, school, social, medical, etc., that have not been mentioned elsewhere in this questionnaire?

____

____

Who are the important people in your life? (close or important relationships)

____

____

What type of things have caused you stress in the past year?

____

____

____

X. SOCIAL INTERACTION

This client has (many, average, few, no) friends. ___________________________________

Please select any behaviors that are observed in this client:

_____ appears uninterested or does not ask about opinions, comment, thoughts or perspective of others?

_____ has poor eye contact during conversations?

_____ seems unaware of the “unwritten rules” of social interaction?

_____ has a very serious or pedantic way of talking

_____ speaks loudly or has an unusual cadence or tone of voice?

_____ does not understand jokes or figures of speech, or interprets too literally (i.e. “kick the bucket?”)

_____ seems fascinated and/or very knowledgeable about particular subjects

_____ becomes upset by changes in routine

_____ has rituals or routines that must be followed precisely?

_____ difficulty with or lack of interest in maintaining friendships?

_____ has sensitivities to textures or specific food items?

_____ odd motor mannerisms?

XI. OTHER SPECIALISTS CONSULTED

1. Name ____ Date ____________________
Findings ____
____

2. Name ____ Date ____________________
Findings ____

3. Please add any additional information you feel will be helpful to us.

____
____
____
____
____
____
____
____
____

PLEASE INCLUDE COPIES OF ALL PREVIOUS EVALUATION REPORTS, COPIES OF ANY STANDARDIZED TESTING (STAAR, SAT/ACT, ISEE ETC.) AND ANY 504 OR SPECIAL EDUCATION PAPERWORK.