---ADULT---

Comprehensive Neurodevelopmental History and Interview
CNHI, Version 4-2009 with Domains Model © Bluestem Center

The information you provide on these pages is an extremely valuable part of your evaluation. Please complete each item with careful consideration before our first office visit. This information will be part of your medical record, and is protected under Privacy Acts. ***Please fill out using pen.*** *Thank you for your assistance.*

General Information

Your Name _____ Date _____

Current Address _____

City _____ County _____ State _____ Zip ____

Home Phone_____Cell Phone_____Work Phone_____

(Please indicate preferred phone)

Date of Birth _____ Age _____ Sex: ☐ Female ☐ Male

Are you employed?_____ Employer _____

What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

Spouse or Partner's Name:_____

Emergency Contact, Name and Number:_____

Relation to you:_____

Please bring copies of any previous evaluation or treatment reports to your appointment.

 Initial

This evaluation is for (check all that apply):

☐ First-time evaluation ☐ Second opinion ☐ Updated evaluation

☐ Transfer care from _____

☐ Consider medication for _____

☐ Other: _____

How did you learn about Bluestem? _____

Should we send a summary to a health professional or other person? ☐ Yes ☐ No
Please supply address:

.

Name_____

Address_____

Phone_____Fax_____

What are your main concerns at this time? _____

_____

_____

What help are you seeking from Bluestem Center? _____

_____

_____

What are some of your strengths, positive points, abilities, etc.?

_____

_____

_____

 Initial

Please list any social workers, therapists, or other professionals currently involved in your care:

1. Name_____

   Address_____

   Phone_____Fax_____

2. Name_____

   Address_____

   Phone_____ Fax_____

Evaluation and Treatment History

1. List any previous evaluations for yourself for mental health care:

Name of Professional or Clinic: _____

When: _____

_____

2. Have you ever had to be hospitalized for a mental health problem? ☐ Yes ☐ No

3. Have you found information about your problem, if yes, where? ☐ Yes ☐ No

   ☐ Books ☐ Magazines ☐ Friends, family ☐ Support group

   ☐ School professionals ☐ Health care professionals

   ☐ TV specials ☐ Other: _____

   ☐ Have not found any information yet

4. If you have taken psychiatric medications in the past, please check the box and circle the name of the medicine.

   ☐ Stimulants: (Methylphenidate: Concerta, Metadate/CD, Methylin/ER, Daytrana, Ritalin/SR/LA, Quillivant, Focalin, Daytrana, Adderall XR, mixed amphetamine salts, Dextroamphetamine)

   ☐ Antidepressants: (Paxil, Prozac, Zoloft, Luvox, Celexa, Effexor, Wellbutrin, Pristiq)

   ☐ Antipsychotics: (Zyprexa, Risperdal, Haldol, Mellaril, Orap, Seroquel, Geodon, Abilify, Latuda, Clozaril)

   ☐ Mood stabilizers: (Depakote, Tegretal, Trileptal, Neurontin)

   ☐ Benzodiazepines: (Valium, Klonopin, Temazepam, Xanax, Ativan, others)

   ☐ Sleeping Medicines

   ☐ Yes, but I don't know the name

   ☐ Other: _____

 Initial

Education and Employment History

Please give the **name** and **location** of schools attended, military and work experience.

Please share any important events that happened during those times. Including difficulties, learning or behavioral problems and any special services provided to you. Also, list any strengths you had during these times of your life.

1. Did you ever have special education services or extra tutoring while in school?

☐ Yes ☐ No

2. As a child, did you have discipline problems leading to suspensions or being expelled?

☐ Yes ☐ No

3. High School: _____Class of: _____

☐ Graduated ☐ GED ☐ Did not finish

4. College or other: _____

Years Completed_____ Degree and Year _____

5. Graduate or Vocational Training: _____

Years Completed _____ Degree or Certification _____

6. Military Experience:

☐ No Yes: Branch: _____ Years Served: _____

7. Employment History:

Company Title or Task Years

_____

_____

_____

_____

_____

 Initial

Social History

1. Where do you live now?

☐ House in town ☐ Apartment ☐ House in the country ☐ Farm

☐ Mobile home ☐ Temporary housing ☐ Other _____

2. Who lives with you?

Name	Relationship	Age

3. Please list immediate family members (parents, children, siblings) not living with you:

Name	Relationship	Age	Living where

4. Do you have any pets? ☐ Yes ☐ No If yes, list: _____

5. Hobbies or interests (camping, science fiction, sports, hunting, reading, etc.):

_____

6. Do you attend church or other house of worship?

☐ Occasionally ☐ Regularly ☐ No

Name _____

7. How does your faith contribute to or help with your problem?

_____

_____

 Initial

8. Check the life events you've experienced in the past three years:

- ☐ Parents divorced or separated
- ☐ Family member ill or injured
- ☐ Absence of a spouse for a week or more
- ☐ Tension in the home
- ☐ Financial problems
- ☐ Loss of a close friend
- ☐ Car accident
- ☐ Legal problems
- ☐ Marital or couple's problems
- ☐ Family move
- ☐ Death in the family
- ☐ Death of a pet; acquired a new pet
- ☐ Changed jobs or lost a job
- ☐ Arrival of a family member
- ☐ House fire, natural disaster
- ☐ Family member was a crime victim
- ☐ You witnessed or experienced physical, emotional or sexual abuse

10. Have you ***ever*** (as a child or an adult) been a victim of:

- ☐ Physical abuse
- ☐ Emotional or verbal abuse
- ☐ Crime
- ☐ Witnessed violence in the home
- ☐ Sexual abuse
- ☐ Harassment at school or work
- ☐ Witnessed crime in the community
- ☐ None

11. Have you ever had a life-threatening experience (house fire, car accident, etc.)?

☐ No ☐ Yes If yes, describe: _____

12. Does anyone in your family have special needs or health problems (chronic illness, handicap, etc.)? If yes, who and what? _____

13. Are you satisfied with your friendships? ☐ Yes ☐ No

14. Do you wish you had more friends or more skills in this area? ☐ Yes ☐ No

15. How often do you spend time with friends?

_____

16. Are you satisfied with your relationships with your parents and siblings? ☐ Yes ☐ No

 Initial

17. Do you have a supportive extended family (grandparents, aunts, uncles, cousins) who would help you if you asked? ☐ Yes ☐ No

18. Do you have concerns about getting along with people in your workplace? ☐ Yes ☐ No

19. How stressful is your current work environment? _____

_____

Legal History

1. Do you have any pending legal concerns? ☐ Yes ☐ No

If yes, please explain: _____

_____

2. Have you ever been arrested? ☐ Yes ☐ No

If yes, please explain: _____

_____

3. Have you ever been required to complete a class, go to jail, or sent to prison? ☐ Yes ☐ No

If yes, please explain: _____

_____

Financial

1. Do you have enough income to meet basic needs with some left over for fun? ☐ Yes ☐ No
2. Will cost be a factor or problem in seeking treatment? ☐ Yes ☐ No
3. Do you have problems with impulse buying, shopping, or gambling? ☐ Yes ☐ No
4. Are you under stress from debt or other financial issues? ☐ Yes ☐ No

 Initial

Family History: Please indicate whether any **blood relatives** have any of the following problems:

	Self	Brothers Sisters	Natural Mother	Mother's Relatives	Natural Father	Father's Relatives
Learning disabilities, dyslexia, speech or special education classes	☐	☐	☐	☐	☐	☐
Mental retardation, autism, other neurodevelopmental problems	☐	☐	☐	☐	☐	☐
Attention deficits and/or hyperactivity	☐	☐	☐	☐	☐	☐
Problems with anger or aggression	☐	☐	☐	☐	☐	☐
Bipolar or manic-depressive, moody	☐	☐	☐	☐	☐	☐
Anxieties, fears, phobias, panic attacks	☐	☐	☐	☐	☐	☐
Obsessive-compulsive disorder	☐	☐	☐	☐	☐	☐
Tics or other nervous habits, Tourette's	☐	☐	☐	☐	☐	☐
Depression for more than 2 weeks,	☐	☐	☐	☐	☐	☐
Suicide or threatened suicide	☐	☐	☐	☐	☐	☐
Psychosis or schizophrenia, hospitalized for mental or emotional problems.	☐	☐	☐	☐	☐	☐
Thyroid problems (over- or under-active)	☐	☐	☐	☐	☐	☐
Heart problems or sudden unexpected death of unknown cause under age 50	☐	☐	☐	☐	☐	☐
Alcohol or drug abuse or heavy use	☐	☐	☐	☐	☐	☐
Physical or sexual abuse	☐	☐	☐	☐	☐	☐
Seizures or epilepsy	☐	☐	☐	☐	☐	☐
Legal problems, arrests, jail/prison time, court probation, "always in trouble"	☐	☐	☐	☐	☐	☐
Serious or chronic medical problems:	☐	☐	☐	☐	☐	☐
Gambling, shopping or other compulsions	☐	☐	☐	☐	☐	☐

 Initial

Adult Health History

Date of last physical exam: _____ Physician or Clinic:_____

Chronic (ongoing) medical problems/illnesses (Examples: high blood pressure, asthma…):

_____

_____

Serious childhood illnesses

_____

_____

Are your immunizations up to date?: ☐ Yes ☐ No ☐ Unsure

Surgery or Operations:

_____

_____

_____

Injuries (requiring medical care):

_____

_____

Hospitalizations (for any reason):

_____

_____

Inherited or metabolic disorders:

_____

_____

Sleep Patterns:

- ☐ Difficulty falling asleep
- ☐ Hard to get up and going
- ☐ Difficult to wake even with good night sleep
- ☐ Fall asleep during routine activity
- ☐ Nightmares
- ☐ Watch TV in bedroom
- ☐ Snoring
- ☐ Early or frequent waking
- ☐ Seem sleepy during the day
- ☐ Nap 4 or more times/week
- ☐ Sleep walking
- ☐ Night sweating
- ☐ Cramps/leg jerking

Usual time you go to bed: _____Lights out time: _____ Time asleep: _____

Awake time: _____ Time you get out of bed for the day: _____

 Initial

Eating Pattern:

Have you been gaining or losing weight recently? On purpose?

Diet: ☐ General ☐ Vegetarian ☐ Vegan ☐ Other: _____

Do you have appetite control or eating problems ☐ Yes ☐ No

Are there any foods you should avoid? ☐ Yes ☐ No

Exercise Pattern:

☐ Athletic, regular sports training _____ times per week

☐ Cardio exercise and/or weight training _____ times per week

☐ Play sports, bike, swim, or other activities _____ times per week

☐ Walk, low-impact exercise _____ times per week

☐ Fairly sedentary – no regular exercise

Chemical Use:

Caffeine : ☐ Never ☐ <1/week ☐ 2-6/week ☐ Daily

Alcohol : ☐ Never ☐ Abstaining ☐ Weekly ☐ Daily ☐ Occasional

Tobacco : ☐ Never ☐ Quit ☐ Daily

Does anyone in your house currently abuse drugs or alcohol? ☐ Yes ☐ No

Would you like information or a referral to help you quit smoking? ☐ Yes ☐ No

CAGE Questionnaire

• Have you ever felt you should **C**ut down on your drinking? ☐ Yes ☐ No

• Have people **A**nnoyed you by criticizing your drinking? ☐ Yes ☐ No

• Have you ever felt bad or **G**uilty about your drinking? ☐ Yes ☐ No

• Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? ☐ Yes ☐ No

 Initial

Current medications (include vitamins, herbs, and supplements):

Name	Dose	Frequency	Purpose

Have you had a bad reaction or allergy to any medicines? ☐ Yes ☐ No

Are there any medicines that you have been told to avoid? ☐ Yes ☐ No

 Initial

Please circle if you have ever experienced any of the following:

General:

weight loss, weight gain, weakness, fatigue, fevers, sweats, worries about health, pain

other _____

Skin:

skin rash, lumps, sores that won't heal, hair loss, change in hair texture, change in nails, warts, fungus, lice, serious burns, scalding, scars, acne requiring doctor's attention, birthmarks, unusual moles, itching, psoriasis, atopic dermatitis, eczema, other _____

Eyes:

Glasses/contacts, pain, redness, excessive tearing, double vision, changes in vision, injury to eye, lazy eye, glaucoma, dry eyes, other _____

Ears:

ringing in the ears, ear aches, dizziness, frequent infections, ear tubes, hearing loss, hearing aids, problems with external ear, other _____

Nose and Sinuses:

congestion, hay fever, nose bleeds, sinus problems, trouble breathing, other _____

_____

Mouth and Throat:

bleeding gums, frequent sore throats, sore tongue, trouble swallowing, hoarseness, teeth problems, dry mouth, taste changes, mouth sores, other _____

Respiratory:

asthma, coughing up blood, wheezing, short of breath, pneumonia, tuberculosis, bronchitis, snoring, sleep apnea, COPD, emphysema, other _____

 Initial

Cardiac:

chest pain, heart racing or pounding, dizziness, fainting, high blood pressure, swelling of hands or feet, heart murmur, fainting, poor stamina, other_____

Gastrointestinal:

heartburn, nausea/vomiting, constipation, diarrhea, blood in stools, abdominal pain, food intolerance (lactose, gluten), liver or gall bladder problems, hepatitis, jaundice (yellow eyes), stool incontinence, irritable bowel, other _____

Urinary:

trouble starting/stopping your urine, frequent urination, burning on urination, blood in urine, incontinence, wetting, urgency, other _____

Reproductive/sexual:

1. masturbation problems, sexually transmitted diseases, poor sex drive, excessive sex drive, other concerns

2. Females: number of pregnancies _____ number of deliveries _____miscarriage or abortion_____

Date of last PAP _____ method of birth control _____

breast masses/tenderness, abnormal PAP smear, irregular menses, painful intercourse, vaginal discharge, yeast

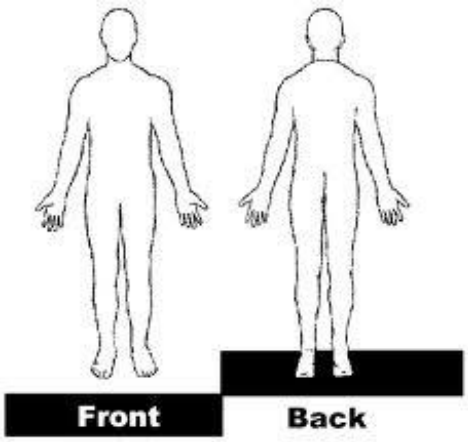
3. Males: problems with erection or ejaculation, hernias, testicular pain or masses, sores on genitals, potency concerns, Other_____

Musculoskeletal:

joint pain, arthritis, stiffness, muscle pains or cramps, limitation of motion or activity, broken bones, hot red swollen joints, weakness, frequent sprains, restless/jittery legs, fibromyalgia, back problems, scoliosis, sciatica, other _____

 Initial

Put and "X" on problem areas:



Circulatory:

varicose veins, blood clots, leg cramps, cold hands or feet, Raynard's

other _____

Neurological:

fainting, blackouts, seizures, paralysis, local weakness, numbness, tingling, tremor, dizziness, drowsiness, confusion, staring spells, memory problems, muscle ties, numbness, migraines, headaches, loss of consciousness, concussions (now or past), other _____

Endocrine:

thyroid problems, heat or cold intolerance, excessive sweating, diabetes, excessive thrist, hunger, urination, growth problems (height or weight), warm moist skin, flushed face, dry coarse skin/dry hair, excess body hair, excess sweating, breast leakage, other _____

Hematological:

anemia, easy bruising or bleeding, past blood transfusion, blood clotting disorder, low iron, excessive hemoglobin, sickle cell trait, sickle cell disease

other_____

Immune System:

frequent infections, allergies, immune system problems, autoimmune disorder, swollen glands

other: _____

 Initial

Emotional System:

Drowsiness, confusion, hallucinations, intrusive thoughts, suspicious thoughts, nightmares, phobias or excessive fears, guilt that is excessive/regrets, recurring unwanted thoughts, racing thoughts, compulsions, obsessions, low motivation, excessive anger, excessive shyness, unable to stand up for self, altered perceptions: see/hear/smell/taste things that aren't there

Anything else?

_____

_____

_____

 Initial

Screening for "executive functions":

"Executive functions" are like brain subroutines; they control how we process and use information. We're all slightly different. For example, differences in executive functions make accountants and baseball players good at what they do, even though both groups have "normal" brains. Please rate yourself compared to most adults.

	A problem/ not good	sometimes a problem	OK	A skill for me; better than most
Attention Control				
Generate the effort needed to start and finish	☐	☐	☐	☐
Ability to stay alert throughout the day	☐	☐	☐	☐
Ability to decide what's important to focus on	☐	☐	☐	☐
Ability to stay focused on a task	☐	☐	☐	☐
Ability to organize and plan your work	☐	☐	☐	☐
Ability to work independently	☐	☐	☐	☐
Temporal-Sequential				
Memory for sequences - numbers, tasks	☐	☐	☐	☐
Write letters and words in correct order	☐	☐	☐	☐
Awareness of time passing; finishing on time	☐	☐	☐	☐
Being on time for things	☐	☐	☐	☐
Trouble with tracking deadlines	☐	☐	☐	☐
Trouble telling time on a clock with a dial	☐	☐	☐	☐
Trouble remembering events, birthdays, anniversaries	☐	☐	☐	☐
Spatial Awareness				
Run into things, knock things over	☐	☐	☐	☐
Able to read maps	☐	☐	☐	☐
Memory for directions-to and from a place	☐	☐	☐	☐
Put together puzzles, build models	☐	☐	☐	☐
Know right from left	☐	☐	☐	☐
Careful or skilled driver	☐	☐	☐	☐
Make things with my hands	☐	☐	☐	☐

 Initial

	A problem/ not good	sometimes a problem	OK better than most	A skill for me;
Memory				
Short-term memory for instructions, tasks	☐	☐	☐	☐
Can remember one thing while doing something else (multi-tasking)	☐	☐	☐	☐
Ability to follow a 5-step plan	☐	☐	☐	☐
Lose things like keys, forget parking spot	☐	☐	☐	☐
Memory for faces and names	☐	☐	☐	☐
Language				
Ability to write and speak your thoughts clearly	☐	☐	☐	☐
Sometimes misinterpret what others are saying	☐	☐	☐	☐
Find words easily when speaking	☐	☐	☐	☐
Use words/vocabulary appropriately	☐	☐	☐	☐
Use clear/neat handwriting	☐	☐	☐	☐
Read for pleasure	☐	☐	☐	☐
Gross & Fine Motor Skills				
Coordination and balance	☐	☐	☐	☐
Eye-hand coordination	☐	☐	☐	☐
Learned to ride a bicycle easily	☐	☐	☐	☐
Ability to play sports	☐	☐	☐	☐
Ability to do fine needlework or modeling	☐	☐	☐	☐
Math				
Ability to balance checkbook or do sums	☐	☐	☐	☐
Multiply & divide without a calculator	☐	☐	☐	☐
Calculate areas and angles	☐	☐	☐	☐
Work with fractions	☐	☐	☐	☐
Make/read graphs	☐	☐	☐	☐

 Initial

	A problem/ not good	sometimes a problem	OK	A skill for me; better than most
Social Skills				
Can interpret others' feelings correctly	☐	☐	☐	☐
Use humor appropriately	☐	☐	☐	☐
Able to ask for help or feedback	☐	☐	☐	☐
Resolve conflicts appropriately	☐	☐	☐	☐
Make and maintain friendships easily	☐	☐	☐	☐
Supervise others	☐	☐	☐	☐
Abstract Thinking				
Problem solving ability	☐	☐	☐	☐
Creativity/brainstorming	☐	☐	☐	☐
Logical thinking	☐	☐	☐	☐
Make decisions about right and wrong	☐	☐	☐	☐
Foresee consequences of actions	☐	☐	☐	☐
Able to receive criticism well	☐	☐	☐	☐
Sensory Development	definite Issue for me	sometimes	used to be	never a problem
Sensitive to clothing textures	☐	☐	☐	☐
Fidgety: rock or bounce legs while sitting Or have to keep hands busy	☐	☐	☐	☐
Bothered by sounds (refrigerator, fans, etc.)	☐	☐	☐	☐
Bothered by bright lights	☐	☐	☐	☐
Sensitive to smells and odors	☐	☐	☐	☐
Trouble maintaining eye contact	☐	☐	☐	☐
Sensitive to food textures or tastes	☐	☐	☐	☐
Like spinning, swinging, or being squeezed	☐	☐	☐	☐

 Initial