91-1010 Shangrila Street, Suite 307
Kapolei, Hawaii 96707
Phone: 808-312-2827
www.hawaiisakuracenter.com

DEMOGRAPHIC FORM-ADULT EVALUATION

General Information

Full Name: _____ Today's Date: ____/____/_____ Date of Birth: ____/____/_____

Street Address (includeZIP code):

_____

Phone Numbers:
Home: _____ Is it okay to leave a detailed message at this number? Yes _____ No _____

Cell: _____ Is it okay to leave a detailed message at this number? Yes _____ No _____

E-Mail Address: _____
Do I have your consent to email an appointment reminder prior to sessions? Yes _____ No _____
Do I have your consent to email digital copies of:

1) Records: Yes _____ No _____

2) Billing statements: Yes _____ No _____

Emergency Contact: _____ Phone #: _____

Please tell us a little more about yourself:

Gender/Preferred Pronouns: _____

Ethnicity/Cultural identity: _____

Spiritual beliefs: _____

Disabilities (any): _____

Sexual orientation: _____

Occupation and/or School & Major: _____

Handedness (right/left/ambidextrous): _____

Who referred you to our service? Please provide contact information:

_____

Is this referral a result of or related to any legal or court proceedings? If so, please provide name of attorney.

_____

Please list the reason(s) you are seeking this evaluation:

_____

_____

How long have these problems occurred? (number of weeks, months, years):

_____

Have you had previous neuropsychological testing? Yes _____ No _____

If Yes, where? _____ When?_____

Have you had any additional testing (e.g., psychoeducational, speech/language?) Yes _____ No _____

If Yes, where? _____ When?_____

**If you answered Yes to either of the above questions, please attach or otherwise provide report(s).*

Please list any other healthcare providers involved in your care (e.g., neurologists, other physicians, occupational therapists, etc.):

_____

_____

Developmental/Medical History

Pregnancy and Birth (your own, not your children's – leave blank if unknown)

Pregnancy/Birth/Delivery Complications? Please Describe:

_____

_____

Medications used during pregnancy?

_____

Did your mother engage in any of the following during pregnancy?

Yes _____ No _____ Smoking? Frequency? _____
Yes _____ No _____ Drug intake? Type? _____ Amount/Frequency? _____
Yes _____ No _____ Alcohol consumption? Amount/Frequency? _____

Length of pregnancy? (weeks): _____ Age of mother at birth: _____ Birth weight: _____ lbs. _____ oz.

Birth length: _____ APGAR scores? _____/_____

Type of delivery (check please): spontaneous _____ induced _____cesarean _____
with instruments _____ breech _____

Any complications for mother or infant (yourself) after birth? Please explain:

_____

_____

Developmental Milestones
Yes _____ No _____ Did you enjoy cuddling?
Yes _____ No _____ Were you fussy or irritable?
Yes _____ No _____ Were you more active than other babies?
Yes _____ No _____ Was your development significantly different than your siblings? If yes, please explain:

_____

_____

At what age did you first do the following (indicate with year and month of age).

Turn Over _____ Crawl _____ Stand Alone _____ Walk Alone _____

Walk Upstairs _____ First Words _____ First Phrases _____

Toilet Trained during the day by age 5? Yes _____ No _____

Did bed wetting or soiling occur after training? Wetting _____ Soiling_____ If yes, until what age? ____

Did you have any speech difficulties?

_____

Motor difficulties (e.g. clumsiness)?

_____

Medical History

Has your medical history been normal/unremarkable? Yes _____ No _____
If no, please explain:

_____

_____

Have you received any medical diagnoses? Yes _____ No _____
Please explain:

_____

_____

Check All that Apply:

Yes___	**No**___	Have you completed genetic testing?	**Yes**___	**No**___	Headaches?
			Yes___	**No**___	Meningitis?
Yes___	**No**___	Have you had an MRI	**Yes**___	**No**___	Seizures?
Yes___	**No**___	Have you had an EEG	**Yes**___	**No**___	Asthma?
Yes___	**No**___	Frequent ear infections?	**Yes**___	**No**___	Slow/fast growth?
Yes___	**No**___	Were ear tubes ever placed?	**Yes**___	**No**___	Head injury?
Yes___	**No**___	Hearing problems?	**Yes**___	**No**___	Allergies?
Yes___	**No**___	Vision problems?	**Yes**___	**No**___	Hospitalizations?

Yes___ **No**___ Have you experienced anything you would call traumatic (physical, verbal, or emotional abuse; unwanted sexual experiences; accidents or other events)?

Have you ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications do you currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your sleep routine:

Typical bed time: _____ Typical wake time: _____ Trouble falling asleep? **Yes___ No___**

Trouble staying asleep? **Yes___ No___**Trouble waking up early? **Yes___ No___**

Any other sleep problems? Explain:

_____

_____

Describe your diet:

_____

_____

Describe your current level and type(s) of exercise:

_____

_____

Mental Health History

List any previous or current mental health diagnoses:

_____

_____

Have you received therapy services or counseling in the past? **Yes___ No___**

Name of provider: _____ Dates: _____

Name of provider: _____ Dates: _____

Name of provider: _____ Dates:_____

Are you currently seeing a psychiatrist for medication? **Yes**___ **No**___Have you in the past? **Yes**___ **No**___

Name of Psychiatrist: _____ Dates of treatment: _____
Medication(s) Prescribed:

_____

Is there a history of self-harm or suicidal thoughts, threats, or attempts? Please explain:

_____

_____

Have you ever been hospitalized for mental health concerns? Please explain:

_____

_____

Do you have a history of angry outbursts? **Yes**___ **No**___ If yes, please explain:

_____

Have you ever physically assaulted another person, animal, or object? **Yes**___ **No**___ If yes, please explain:

_____

Psychosocial Functioning

Describe your personality:

_____

_____

What are your non-academic strengths?

_____

What are your non-academic weaknesses?

_____

How do you spend your free time?

_____

What is your current level of alcohol and/or drug use?

Alcohol:_____ Recreational drugs: _____

How is your social group? Do you have close friends? Any trouble initiating or maintaining relationships?

_____

_____

_____

Please place a mark next to behaviors that you believe you experience to an *excessive or exaggerated degree* when compared to others your age.

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with others
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Impulsive (does things without thinking)
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor
- ❑ History of vocal or motor tics
- ❑ Poor sense of danger/risk
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug use
- ❑ Alcohol use

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Excessive snoring during sleep
- ❑ Decreased need for sleep without getting tired
- ❑ Eating excessively
- ❑ Eating Poorly

Social

- ❑ Prefer to be alone
- ❑ Excessively shy or timid view
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Not sought out for friendship by peers
- ❑ Excessive daydreaming and fantasy life
- ❑ Difficulty seeing another person's point of view
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Does not appreciate humor

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ "Clumsy" in general

Academic History

Did you ever have an IEP or 504 Plan, or other modified learning program or participation in special education services when younger? **Yes___ No___**

If yes, please describe:

_____

_____

What was your high school GPA: _____
What was/is your college GPA: _____
Grad school GPA: _____

How do you generally perform on standardized tests?

_____

What are your strongest and weakest points, academically?

_____

Legal History

Have you been involved with the court currently or in the past? **Yes___ No___** Date(s):_____
Describe:

_____

_____

Currently on Probation? **Yes___ No___** Probation Officer: _____ Phone #: _____

Family History

Are you (choose one): **Married Living Together Separated Divorced Single**

If married, for how long?

_____

If separated or divorced, when?

_____

Do you have children? Ages?

_____

Who else lives in your home?

_____

_____

Have any of the following diseases occurred among your blood relatives (parents, aunts, uncles, grandparents)? Check all that apply:

❑ Allergies
❑ Amnesia
❑ Asthma
❑ ADHD
❑ Bleeding tendency
❑ Depression
❑ Cancer
❑ Suicide
❑ Learning problems
❑ Deafness
❑ Diabetes
❑ Glandular problems
❑ Heart diseases
❑ High blood pressure
❑ Kidney disease
❑ Alcohol/drug problem
❑ Anxiety
❑ Autism/Asperger's
❑ Intellectual disability/ cognitive delay
❑ Seizures
❑ Cerebral Palsy
❑ Migraines
❑ Muscular Dystrophy
❑ Schizophrenia
❑ Dementia/cognitive decline
❑ Other (specify):
_____