Family Tree Therapies
identify. understand. empower.

Adult Intake History and Questionnaire

Please complete appropriate sections to help us serve you.

All information contained in this document is strictly confidential.

Today's date: _____

Name: _____ Date of Birth: _____

Occupation: _____

Primary Concerns

Please check all that apply:

- □ Speech or Language
- □ Motor Skills
- □ Social Skills
- □ Sensory Processing
- □ Behavior
- □ Emotion
- □ Attention and Focus
- □ Anxiety

Have you received previous treatment for your concerns? Describe: _____

_____

_____

How long have you had concerns? _____

Have they improved, remained the same, gotten worse? _____

_____

Have you ever been to a naturopath, chiropractor, osteopath, PT, or other health professional? _____

_____

_____

For your concerns or another reason? _____

_____

What are your primary goals for therapy? _____

_____

Birth History

Were you adopted? _____ If yes, at what age and from where? _____

Were there complications during your mother's pregnancy (illness, infection, stress)? If yes, please describe:_____

_____

Circle one: Post mature Full term Premature

Length of pregnancy (in weeks): _____

Circle any applicable: Forceps? Vacuum? C-section?

Sleep difficulties as an infant? _____

History of Torticollis or Plagiocephaly? _____

Bottle or Breast-fed as an infant? How long? _____

Did you use a pacifier? _____

As accurately as you can remember were there concerns meeting developmental milestones (rolling, sitting, crawling, walking, dressing, riding bike, tying shoes, using writing utensil, using scissors)?

Describe: _____

_____

_____

Medical and Health History

Do you have a medical diagnosis? _____

_____

Are you currently taking medications? Please list: _____

_____

Have you ever had surgery or been hospitalized/treated for accident or illness? Please list & date:

_____

_____

_____

_____

Please list relevant family history/genetic history: _____

_____

_____

Have you had recent immunizations? If yes, which: _____

_____

Check all that apply and provide information while relevant:

- □ Allergies? (List) _____
- □ History of seizures? _____
- □ History of fevers? _____
- □ History of Ear Infections? Tubes? _____
- □ Glasses _____
- □ Hearing Aids _____
- □ Wear orthotic devices (currently or previously) _____
- □ Cardiac concerns _____
- □ Frequent urination _____
- □ Restlessness _____
- □ Poor temperature regulation _____
- □ Dizziness _____
- □ Fainting / black outs _____
- □ Joint pain _____
- □ Back pain _____
- □ Panic attacks _____
- □ Migraines / headaches _____

Did you have any childhood illnesses? *(please circle)*

Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio

Do you experience jaw pain? YES NO

If yes, when does it occur and when is your pain the greatest? _____

Most tolerable? _____

Describe your diet *(circle any that apply)*:

Normal Picky eater Restricted Poor nutrition Unsafe Limited Other

Do you have aversions to any foods based on:

Texture Temperature Crunchy foods Chewy Foods Food Color

Intense Flavors Mixed Textures

Do you have difficulty with:

Sucking through a straw Food falling out of mouth Drooling

Frequent choking Swallowing

How much water do you drink daily? _____

How much caffeine do you drink daily? _____

Do you drink alcohol? YES NO

Do you have any dietary restrictions? Food sensitivities? _____

_____

Have you experienced any recent change in appetite? _____

Recent weight loss or gain? _____

Have you ever experienced physical trauma? To which part of the body? _____

_____

_____

Have you ever experienced an emotional trauma? Have you received previous treatment?_____

_____

_____

Is there a diagnosis connected to your experience of this trauma? _____

_____

Breathing Patterns

Please check all of the following that apply, *and* rank on a scale from 1 to 3.

1 - rare / 2 - sometimes / 3 - always

Do you experience:

- □ _____ Shallow breathing, using the upper chest to breathe
- □ _____ Erratic breathing (e.g. a deep breath every few minutes; rapid breathing spaced with long pauses; breathing without pause)
- □ _____ Fast or deep breathing
- □ _____ Yawning or sighing
- □ _____ Breathing through mouth
- □ _____ Difficulty in taking a deep breath
- □ _____ Short of breath, breathless
- □ _____ Chest tightness or constriction
- □ _____ Airways are extra-sensitive
- □ _____ Excessive mucus production
- □ _____ Coughing
- □ _____ Allergies, rhinitis, hay fever
- □ _____ Sneezing
- □ _____ Blocked or running nose
- □ _____ Reduced sense of smell
- □ _____ Bad breath
- □ _____ Dry mouth
- □ _____ Dental or gum problems
- □ _____ Throat clearing repeatedly
- □ _____ Ringing in the ears
- □ _____ Light-headed or feeling dizzy
- □ _____ Pounding, rapid or erratic heartbeat
- □ _____ High blood pressure
- □ _____ Varicose veins

- □ _____ Colds, flu, or chest infections
- □ _____ Prone to sickness
- □ _____ Visual disturbances (e.g. flashes or shadows before the eye, blurred or tunnel vision, impaired night vision)
- □ _____ Poor concentration, mental fatigue, confusion, forgetful, spaced out
- □ _____ Feeling tense, apprehensive, anxious, panicky, or fearful without reason (e.g. fear of stuffy rooms)
- □ _____ Short temper, irritable
- □ _____ Mild depression
- □ _____ Mild obsession in regard to habits, objects or people
- □ _____ Frequent urination
- □ _____ Nausea, butterflies in stomach
- □ _____ Bloated abdomen, flatulence, or belching
- □ _____ Constipation with intermittent diarrhea
- □ _____ Loss of libido
- □ _____ Impotence
- □ _____ Trembling, tic, or twitching
- □ _____ Tingling or numbness in fingers, feet, or lips
- □ _____ Cold hands and feet
- □ _____ Itching, dry skin, eczema, or rashes
- □ _____ Sweaty palms/feet/armpits or feeling hot all over
- □ _____ Hot or cold flushes
- □ _____ Licking dry lips
- □ _____ Pains in bones or joints
- □ _____ Headaches
- □ _____ Muscle weakness, jelly legs
- □ _____ Erratic blood sugar levels

Educational History

Did you ever have difficulty with any of the following?

- □ Executive functioning (planning, organizing work, finishing tasks)
- □ Following directions
- □ Remembering information
- □ Handwriting/Keyboarding
- □ Copying from far away

Family History and Interactions

Marital status: _____

Do you have children? If yes, how many and what are their ages? _____

_____

_____

With whom do you live? _____

_____

_____

Do you have difficulty participating in social/family related gatherings/hobbies/interests because of your concerns? _____

_____

Work and Leisure

Are you currently employed? _____

How many hours a week do you work? _____

How much of the day do you spend sitting? _____

How much of the day do you spend working on a computer? _____

Do you have any hobbies? _____

_____

What kind of social activities do you enjoy/participate in? _____

_____

Do you participate in fitness related social activities? _____

_____

Emotions

Please check any of the following that apply:

- □ I have difficulty expressing emotions
- □ Easily anxious/overwhelmed/frustrated
- □ Difficulty getting along with others
- □ I can be impulsive, unaware of danger, or accident prone
- □ Withdraw from groups or stay on outskirts
- □ Mood swings
- □ My emotions escalate quickly
- □ Difficulty planning, organizing, or problem solving
- □ Difficulty initiating interactions
- □ Difficulty meeting role expectations
- □ Exhibit aggressive behavior toward yourself or others
- □ Avoid initiation of social interactions
- □ I have difficulty self-calming
- □ I have difficulty or feel uncomfortable making eye contact
- □ My emotional reactions tend to be: _____
- □ General mood: _____

Motor Skill Questionnaire

What is your hand dominance? _____

Are you more sedentary or active on a daily basis? _____

Please check all that apply:

Do you exhibit the following behaviors?	*Frequently*	*Sometimes*	*Never*	*Comments*
MOTOR SKILL / BODY AWARENESS				
Tire easily with physical activity, poor endurance				

Have difficulty sitting in meetings or while waiting				
Stiff and awkward in movements				
Tense in neck, shoulders				
Clumsy, bump into things, trip frequently				
Difficulty learning new motor skills with multiple steps (ie dance, exercise)				
Take a long time to complete tasks such as dressing, cleaning, etc.				
Hesitant to participate in physical activities				
Difficulty running, jumping, skipping etc.				
Poor posture, slumped forward, learning on one arm, head too close to work, prop on elbows				
Walk on toes				
Use too much force using objects				
Drag/slap/stomp feet or toes when walking				
FINE MOTOR				
Diffiuclty with fasteners, keys, jewelry, doorknobs, ties etc				
Poor pencil grasp, hand fatigues				
Difficulty keyboarding				
Tend to break objects from force of use				
Difficulty finding objects in pocket or purse				
MOVEMENT and BALANCE				
Anxious moving through space (elevators, escalators)				
Avoid activities that challenge balance; poor balance in motor activities				

Difficulty or hesitancy on uneven terrain				
Difficulty or hesitancy while climbing/ descending stairs				
Fall frequently, lose balance easily				
Easily nauseated or ill from movement experiences; motion sickness				What type?
Difficulty sitting still, seek movement				
Use quick bursts of movement versus sustained				
VISUAL MOTOR / VISUAL PERCEPTION				
Difficulty following traffic signs while driving				
Difficulty completing puzzles, use trial and error for placement				
Get lost in new or even familiar places				
Difficulty coordinating eyes to follow a moving object				
Lose place when reading, use finger to keep place				
Eyes fatigue/strain while reading or copying				
Don't look when manipulating objects				
Keep eyes close to work				
Turn head to read across a page or at an angle for reading/writing				
Re-read or skip words while reading				
Duck or blink if a ball or object is thrown to you				
Difficulty finding things in a busy environment				
Turn whole body to look at a person or object				

Environmental Interactions

Please check all that apply:

- □ Avoid certain clothing fabrics
- □ Prefer more or less clothing than is appropriate for the weather
- □ Prefer not to wear shoes
- □ Frequently adjusting clothing for comfort
- □ Dislike getting messy
- □ Difficulty determining the direction of sounds
- □ Sensitive to loud noises or emotional response to loud noises
- □ Dislike the dark or having eyes covered
- □ Overly sensitive to lights/sunlight
- □ Overly sensitive to pain
- □ Under sensitive to pain
- □ Decreased awareness of touch
- □ Dislike being touched
- □ Dislike for grooming activities (washing hair, face, brushing teeth, etc)
- □ Did you ever/ do you now: Bite your fingers, nails, writing utensils etc.

Sleep

How many hours of sleep do you get on average? _____

Check all that you have difficulty with:

- □ Insomnia
- □ Vivid dreams
- □ Nightmares
- □ Shuddering
- □ Snoring
- □ Waking frequently
- □ Grinding teeth
- □ Tired after sleep
- □ Falling asleep
- □ Sleepwalking

Do family members have interrupted sleep as a result? _____

How many times per night do you wake? _____

How many times per night do you wake to urinate? _____

Have you ever/do you currently take medication to assist with sleep? _____

_____

Comments

Is there anything else would you like us to know about you? _____

_____

_____

_____