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: _____ Date of Birth: _____

Name: _____

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:

Check one: ☐ Post mature ☐ Full term ☐ Premature

Length of pregnancy (in weeks): _____

Check 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:

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

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever ☐ Polio

Check all that apply and provide relevant information:

- ☐ 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 _____

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 *(check 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 or 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
- ☐ Other: _____

Family History and Interactions

Marital status: _____

Do you have children? ☐ YES ☐ NO 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?

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				
Difficulty 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?