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Adult Psychological Pre-Testing Questionnaire

Please answer all questions to the best of your ability and bring it to your scheduled psychological testing appointment. All results of your answers will be kept confidential

NAME:

DOB

DATE

GENDER

MARITAL STATUS

WHAT IS YOUR PRIMARY REASON FOR SEEKING PSYCHOLOGICAL TESTING AT THIS TIME ?

WHAT TESTING ARE YOU SPECIFICALLY LOOKING FOR?

WHO IS THE PERSON THAT REFERRED YOU FOR TESTING ?

WHO IS YOUR PRIMARY CARE PHYSICIAN?

PLEASE PROVIDE YOUR SIGNATURE BELOW TO INDICATE THAT WE ARE ALLOWED TO SEND THE RESULTS TO THE ABOVE REFERRAL SOURCE AND YOUR PRIMARY CARE PHYSICIAN

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PLEASE EXPLAIN THE SYMPTOMS RELATED TO SEEKING PSYCHOLOGICAL TESTING AND WHEN THEY FIRST BEGAN

ARE YOU CURRENTLY RECEIVING PSYCHOLGICAL THERAPY? YES NO

IF YES, WHO IS YOUR CURRENT THERAPIST

IF YES, DO YOU KNOW YOUR CURRENT DIAGNOSIS? YES NO

IF YES, PLEASE EXPLAIN BELOW:

WHO GAVE YOU THE ABOVE DIAGNOSIS?

ARE YOU CURRENTLY TAKING ANY PSYCHOTROPIC MEDICATIONS? YES NO

IF YES, WHO PRESCRIBES THESE MEDICATIONS?

PLEASE LIST ALL PSYCHOTROPIC MEDICATIONS, DOSES, AND LENGTH OF TIME YOU HAVE BEEN TAKING THESE MEDICATIONS

PLEASE LIST ANY OTHER MEDICATIONS YOU ARE CURRENTLY TAKING: INCLUDE THE DOSE AND LENGTH OF TIME YOU HAVE BEEN TAKING THESE MEDICATIONS

DO YOU EXPERIENCE ANY SIDE EFFECTS FROM THESE MEDICATIONS? YES NO

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IF YES, PLEASE DESCRIBE THE SIDE-EFFECTS YOU ARE EXPERIENCING

DO YOU SUFFER FROM ANY SERIOUS MEDICAL CONDITIONS? YES NO

IF YES, PLEASE EXPLAIN IN DETAIL BELOW, INCLUDING WHEN THE MEDICAL CONDITION FIRST BEGAN

HAVE YOU EVER BEEN HOSPITALIZED? YES NO

IF YES, PLEASE LIST REASON AND DATES OF HOSPITALIZATION

HAVE YOU EVER HAD ANY PRIOR PSYCHOLOGICAL TESTING YES NO

IF YES, PLEASE LIST DATES, PROVIDER, AND REASON FOR TESTING

WHEN WAS THE LAST TIME YOU HAD A COMPLETE MEDICAL PHYSICAL

WHEN WAS THE TIME YOU HAD A COMPLETE BLOOD PANEL COMPLETED

WERE THERE ANY ABNORMALITIES IN YOUR BLOOD WORK YES NO

IF YES, PLEASE DESCRIBE BELOW AND IF THOSE ISSUES HAVE BEEN ADDRESSED BY YOUR PHYSICIAN

DO YOU DRINK ALCOHOL? YES NO

IF YES, PLEASE LIST HOW MUCH, HOW OFTEN, AND WHAT BEVERAGE YOU PREFER

DO YOU HAVE A PAST HISTORY OF ALCOHOL ABUSE YES NO

IF YES, PLEASE EXPLAIN BELOW

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DO YOU CURRENTLY USE ANY DRUGS? YES NO

IF YES, PLEASE LIST HOW MUCH, HOW OFTEN, AND WHAT SUBSTANCE

DO YOU HAVE A HISTORY OF ANY TYPE OF DRUG ABUSE YES NO

IF YES, PLEASE EXPLAIN BELOW

HAS ANYONE IN YOUR LIFE EVER EXPRESSED CONCERN OVER YOUR ALCOHOL OR DRUG USE ? YES NO

IF YES, PLEASE EXPLAIN HAVE YOU EVER BEEN INVOLVED IN THE LEGAL SYSTEM? YES NO

IF YES, PLEASE EXPLAIN DO YOU CURRENTLY SMOKE GIGARETTES YES NO

IF YES, HOW MUCH PER DAY IF YES, FOR HOW MANY YEARS

IF YES, DO YOU WANT TO QUIT HAVE YOU TRIED TO QUIT IN THE PAST YES NO

DO YOU CURRENTLY CONSUME CAFFEINATED BEVERAGES YES NO

IF YES, PLEASE LIST HOW MUCH, HOW OFTEN, AND WHAT YOU CONSUME

DO YOU SUFFER FROM INSOMNIA YES NO

IF YES, PLEASE EXPLAIN SLEEP ISSUES BELOW

HOW MANY HOURS ON AVERAGE DO YOU SLEEP AT NIGHT

DO YOU TAKE VITAMINS OR SUPPLEMENTS? YES NO

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IF YES, PLEASE LIST TYPE, DOSE, AND FREQUENCY BELOW

HOW WOULD YOU DESCRIBE YOUR OVERALL HEALTH:

DO YOU CURRENTLY EXERCISE ON A REGULAR BASIS? YES NO

IF YES, PLEASE DESCRIBE THE ACTIVITY, DURATION, AND AMOUNT PER WEEK

HAVE YOU HAD ANY RECENT CHANGES IN YOUR WEIGHT? YES NO

IF YES, PLEASE EXPLAIN

HAVE YOU EVER STRUGGLED WITH FOOD ISSUES AND/OR WEIGHT YES NO

IF YES, PLEASE EXPLAIN BELOW

DO YOU HAVE ANY CHALLENGES RELATED TO HEARING, VISION, OR MOBILITY?

DO YOU CURRENTLY HAVE A PARTNER YES NO

IF YES, PLEASE DESCRIBE WHO YOUR PARTNER IS, LENGTH OF RELATIONSHIP, AND IF YOU LIVE TOGETHER

ARE YOU CURRENTLY HAPPY IN THIS RELATIONSHIP YES NO

IF NO, PLEASE EXPLAIN

DO YOU CURRENTLY HAVE ANY CHILDREN YES NO

IF YES, PLEASE LIST NAMES AND AGES OF EACH

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CHILD

ARE YOU CURRENTLY EXPERIENCING ISSUES WITH PARENTING? YES NO

IF YES, PLEASE DESCRIBE DO YOU HAVE ANY CHILDREN WHO DO NOT LIVE WITH YOU YES NO

IF YES, PLEASE EXPLAIN HAVE YOU EXPERIENCED ANY CUSTODY RELATED ISSUES YES NO

IF YES, PLEASE EXPLAIN PLEASE LIST ALL THE CURRENT PEOPLE AND PETS WHO LIVE IN YOUR HOME THAT YOU HAVE NOT MENTIONED ABOVE

DO YOU FEEL SAFE AND COMFORTABLE IN YOUR HOME? YES NO

IF NO, PLEASE EXPLAIN

PLEASE LIST WHO YOUR BIGGEST SOURCES OF SOCIAL SUPPORT ARE: PLEASE LIST PEOPLE THAT YOU GREW UP WITH (PARENTS, SIBLINGS, GRANDPARENTS, ETC)

PLEASE BRIEFLY DESCRIBE YOUR CHILDHOODARE YOUR PARENTS CURRENTLY ALIVE? YES NO

IF NO, PLEASE NOTE WHEN THEY PASSED AWAY IF KNOWN AND FROM WHAT

IF YES, PLEASE EXPLAIN THE NATURE OF THE RELATIONSHIP YOU HAVE WITH YOUR PARENTS

ARE YOU RESPONSIBLE FOR TAKING CARE OF YOUR PARENTS YES NO

DOES ANYONE IN YOUR IMMEDIATE FAMILY SUFFER FROM ANY TYPE OF MENTAL HEALTH ILLNESS? YES NO

IF YES, PLEASE EXPLAIN HAVE YOU EVER EXPERIENCED A TRAUMA? YES NO

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IF YES, PLEASE EXPLAIN WHAT YOU ARE COMFORTABLE SHARING AND WHEN THE TRAUMA TOOK PLACE

IF YES, DID YOU RECEIVE THERAPY FOR THIS TRAUMA YES NO

HAVE YOU EVER EXPERIENCED BEING BULLIED YES NO

IF YES, PLEASE EXPLAIN ARE YOU CURRENTLY EMPLOYED? YES NO

IF YES, PLEASE DESCRIBE YOUR CURRENT JOB, INCLUDING THE NUMBER OF HOURS YOU WORK PER WEEK AND IF YOU ARE HAPPY AT YOUR WORK

DID YOU GRADUATE FROM HIGH SCHOOL? YES NO

DID YOU GRADUATE FROM COLLEGE? YES NO

IF YES, PLEASE LIST WHEN, WHERE, YOUR MAJOR, AND HIGHEST DEGREE EARNED

DID YOU STRUGGLE AT ALL IN SCHOOL? YES NO

IF YES, PLEASE EXPLAIN DID YOU SERVE IN THE MILITARY? YES NO

IF YES, PLEASE EXPLAIN YOUR ROLE.

PLEASE EXPLAIN BRIEFLY WHAT AN AVERAGE DAY LOOKS LIKE FOR YOU (TIME YOU WAKE UP, WHAT YOU DO, RESPONSIBILITIES, TIME YOU GO TO BED, ETC)

PLEASE LIST WHAT TYPES OF ACTIVITES YOU ENJOY DOING FOR FUN

DO YOU ENGAGE IN ANY TYPE OF SELF-CARE? YES NO

IF YES, PLEASE EXPLAIN

ARE YOU ACTIVE IN ANY TYPE OF SPIRITUALITY OR RELIGION? YES NO

IF YES, PLEASE EXPLAIN HOW MANY HOURS A DAY DO YOU SPEND IN FRONT OF A COMPUTER?

HOW MANY HOURS A DAY DO YOU SPEND ON YOUR CELL PHONE ?

HOW MANY HOURS A DAY DO YOU SPEND ON SOCIAL MEDIA?

HOW MANY HOURS A DAY DO YOU SPEND WATCHING TV?

HOW MANY HOURS A DAY DO YOU PLAY VIDEO GAMES?

HAS SCREEN TIME IN ANY WAY AFFECTED ANY OF YOUR RELATIONSHIPS IN A NEGATIVE WAY (WITH FRIENDS, PARTNER, CHILDREN, ETC)? YES NO

IF YES, PLEASE EXPLAIN

DO YOU FEEL COMFORTABLE WITH YOUR FINANCES? YES NO

IF NO, PLEASE EXPLAIN

DO YOU FEEL LIKE YOU HAVE ENOUGH FRIENDS ? YES NO

IF NO, PLEASE EXPLAIN

HOW WOULD YOU DESCRIBE YOUR PERSONALITY? HOW WOULD YOU DESCRIBE YOUR CURRENT LEVEL OF STRESS

IS THERE ANYTHING IN YOUR LIFE THAT YOU WOULD LIKE TO CHANGE? YES NO

IF YES, PLEASE EXPLAIN

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HAVE YOU RECENTLY EXPERIENCED A DEATH OR LOSS YES NO

IF YES, PLEASE EXPLAIN

PLEASE CHECK ANY PROBLEMS BELOW THAT ARE AN ISSUE FOR YOU

DEPRESSION WEIGHT LOSS ANXIETY WEIGHT GAIN ANGER TIME MANAGEMENT RELATIONSHIP PROBLEMS FAMILY RELATIONSHIP ISSUES SUICIDAL THOUGHTS OCCUPATIONAL ISSUES DRUGS HEALTH CONCERNS ALCOHOL PARANOIA PARTNER RELATIONSHIP ISSUES POSTPARTUM DEPRESSION STRESS OCCUPATIONAL ISSUES FINANCIAL CONCERNS GAMBELING SPIRITUAL CONCERNS LYING MEMORY ISSUES STEALING CHILD RELATIONSHIP PROBLEMS NOT RELATING WELL TO OTHERS LONELINESS HEARING VOICES ISOLATION DISSOCIATION POST TRAUMATIC STRESS AVOIDANCE DIFFICULTY CONCENTRATING ADDICTION DIFFICULTY SITTING STILL SEXUAL ISSUES CONFUSION GENDER ISSUES IRRITABILITY POOR BOUNDARIES ISSUES WITH FOOD SELF-INJURY DESTRUCTIVE BEHAVIOR ASSAULTIVE BEHAVIOR SELF-CARE FEELING TAKEN ADVANTAGE OF EATING DISORDER ISSUES HOMICIDAL THOUGHTS SEXUALLY ACTING OUT LACK OF SEXUAL INTEREST ABUSE OF ANIMALS LACK OF REMORSE RECENT DEATH OR LOSS INABILITY TO FEEL ATTACHED REPEATED RELATIONSHIP ISSUES SUDDEN CHANGES IN MOOD

IF THERE IS ANYTHING ELSE THAT YOU FEEL WOULD HELP US WITH YOUR ASSESSMENT, PLEASE LIST BELOW:

PLEASE REMEMBER TO BRING THIS EVALUATION WITH YOU AT THE TIME OF YOUR SCHEDULED ASSESSMENT. YOU CAN ALSO EMAIL THE COMPLETED QUESTIONNAIRE AHEAD OF TIME TO DRCYNTHIAHAWVER@MAC.COM

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I NEED TO HAVE THIS EVALUATION IN ORDER TO COMPLETE YOUR INTAKE SESSION AND PROCEED WITH THE EVALUATION.

YOUR TIME IN COMPLETING THIS QUESTIONNAIRE IS APPRECIATED. IT WILL GREATLY FACILITATE MY ABILITY TO PROVIDE YOU WITH A COMPLEX PSYCHOLOGICAL EVALUATION. I LOOK FORWARD TO MEETING WITH YOU SOON.

SINCERELY
,

DR. CYNTHIA EDWARDS-HAWVER,
PSY.D. LICENSED PSYCHOLOGIST