COMPREHENSIVE EVALUATION

ADULT

Date: _____

Name: _____
(Last) (First) (Middle)

Client Address: _____

City/State/Zip: _____

Date of Birth: _____Age: _____

Handedness: R L

Home Phone:_____ Cell: _____

Business Phone:_____

Email: _____

In case of emergency contact: _____

Relationship Status: _____Partner's Name:_____

Children's Names/Ages: _____

Mother's Name:_____

Father's Name:_____

_____

Names and ages of siblings and any live-in relationships:

_____

_____

Occupation: _____

Referral Source: _____

Please tick and rate the conditions that apply to you by placing a 0, 1, 2 or 3 to indicate the level of severity: 0=not a problem, 1=mild, 2=medium, 3=severe. Please include any additional information about the disorders such as age of onset, length of duration, interventions undertaken, that you consider important.

GENERAL HEALTH:

☐	Sleep				
	Difficulty falling asleep or staying asleep	0	1	2	3
	Difficulty waking	0	1	2	3
	Restless sleep	0	1	2	3
	Sleepwalking or night terrors	0	1	2	3
	Nightmares	0	1	2	3
	Other sleep problems	0	1	2	3
	Bruxism	0	1	2	3
☐	Allergies	0	1	2	3
☐	Asthma	0	1	2	3
☐	Frequent Illness	0	1	2	3
☐	Fatigue	0	1	2	3
☐	Appetite awareness				
	I am aware of my appetite increasing.	0	1	2	3
	I often find myself suddenly aware that I am starving or shaky due to lack of food.	0	1	2	3
	I am always hungry	0	1	2	3
☐	Sense of taste	0	1	2	3

☐	Thirst awareness	0	1	2	3
☐	Heat or cold sensitivity	0	1	2	3
☐	Thyroid disorder	0	1	2	3
☐	Sense of smell	0	1	2	3
☐	Skin problems	0	1	2	3
☐	Low pain threshold	0	1	2	3
☐	High pain tolerance	0	1	2	3
☐	Earaches	0	1	2	3
☐	Bruxism (Teeth Grinding)	0	1	2	3

VISUAL ACUITY:

☐	Double vision	0	1	2	3
☐	Blurred vision	0	1	2	3
☐	Blind spots	0	1	2	3
☐	Eye pain	0	1	2	3
☐	Visual sensitivity to light	0	1	2	3
☐	Poor night vision	0	1	2	3

HEARING:

☐	Hearing loss	0	1	2	3
☐	Ringing in ears	0	1	2	3
☐	Sensitivity to sound	0	1	2	3

CARDIOVASCULAR / PULMONARY:

☐	Breathing problems	0	1	2	3
☐	Heart problems	0	1	2	3
☐	Hypertension	0	1	2	3
☐	Palpitations or tachycardia	0	1	2	3

GASTROINTESTINAL:

☐	Nausea or vomiting	0	1	2	3
☐	Stomach pain	0	1	2	3
☐	Intestinal pain	0	1	2	3
☐	Chronic constipation	0	1	2	3
☐	Irritable bowel	0	1	2	3
☐	Crohn’s Disease	0	1	2	3

PAIN:

☐	Chronic pain or stiffness	0	1	2	3
☐	Headaches	0	1	2	3
☐	Chronic aching pain	0	1	2	3
☐	Chronic nerve pain (burning or stabbing)	0	1	2	3
☐	Muscle cramps	0	1	2	3

NEUROLOGICAL:

☐	Migraines	0	1	2	3
☐	Fainting	0	1	2	3
☐	Seizures	0	1	2	3
☐	Speech problems	0	1	2	3
☐	Tremor or spasticity	0	1	2	3
☐	Weakness	0	1	2	3
☐	Balance	0	1	2	3
☐	Coordination	0	1	2	3
☐	Accident prone	0	1	2	3
☐	Motor or vocal tics	0	1	2	3

ATTENTION AND COGNITIVE:

☐	Academic strengths and weaknesses				
	Reading	0	1	2	3
	Math	0	1	2	3
	Art	0	1	2	3
☐	Sense of direction	0	1	2	3
☐	Concentration	0	1	2	3
☐	Memory	0	1	2	3
☐	Distractibility	0	1	2	3
☐	Impulsivity	0	1	2	3
☐	Hyperactivity	0	1	2	3

UROGENITAL SYSTEM:

☐	Incontinence	0	1	2	3
☐	PMS symptoms	0	1	2	3
☐	Menopausal symptoms	0	1	2	3
☐	Erectile Dysfunction	0	1	2	3
☐	Sexual interest	0	1	2	3

HABITS:

Coffee use (# of cups per day) _____

Alcohol use (type and # of drinks per day) _____

Tobacco use (type and # per day) _____

Diet---anything unusual, recent changes, restrictions _____

Other drug use _____

BEHAVIOR / EMOTIONS:

☐	Mood swings	0	1	2	3
☐	Depression	0	1	2	3
☐	Anxiety	0	1	2	3
☐	Anger or aggression	0	1	2	3
☐	Risk-taking behavior	0	1	2	3

Have you ever been diagnosed with, taken medication for, or think you may have:

Manic-depression _____

Panic attacks _____

Phobias _____

Obsessive-compulsive behaviors _____

Eating disorders _____

Addictions _____

Schizophrenia _____

PERSONAL HISTORY

Please tick next to relevant data that apply to you. Please include any additional information about the disorder or historical circumstance such as age of onset, length of duration, interventions undertaken, that you consider important.

EARLY CHILDHOOD DEVELOPMENT:

Prenatal stress or injury _____
Prenatal drug exposure _____
Difficult labor _____
Difficult birth _____
Premature or late birth _____
Medical problems after birth _____
Adopted at age: _____

Colic _____
Sleep problems _____
Eating problems _____
Activity level _____
Attachment difficulties _____
Emotional development _____
Motor development _____
Language development _____
Chronic ear infections _____
Allergies _____
Asthma _____

PHYSICAL TRAUMAS:

Head injury _____
Concussions _____
Accidents _____
High fever _____
Serious illness _____
CNS infection _____
Drug overdose _____
Poisoning _____
Anoxia _____
Stroke _____

SPORTS

Football _____
Soccer _____
Boxing _____
Martial Arts _____
Dance _____
Baseball _____
Track/Long Distance Running _____
Weight Lifting _____
Other (please specify) _____

History of Trauma & Stress:

Abuse or neglect _____
Family stress _____
School or job stress _____
Recent death in family _____
Illness _____

TREATMENT HISTORY

MEDICATIONS:

Medication	For Condition	Dose	Dates

MEDICAL TREATMENT:

Procedure	For Condition	Description	Dates

PSYCHOLOGICAL THERAPY:

Therapy	For Condition	Therapist	Dates

OTHER THERAPY:

Therapy	For Condition	Therapist	Dates

FAMILY HISTORY

Symptom	Yes	No	Relationship
Alcoholism or Drug Abuse			
Asthma			
Autoimmune Disorders: I Diabetes, Rheumatoid Arthritis Lupus, MS, Scleroderma, etc.			
Thyroid disorder			
Migraine			
Sleep Problems			
Depression			
Manic-depression			
Anxiety			
Phobias			
Panic Attacks			
Motor or Vocal Tics			
Seizures			
Eating Disorders or Obesity			
Addictions			
Obsessive Compulsive Symptoms			
Speech Problems			
Attention Problems			
Hyperactivity			
Learning Problems			
Conduct Problems or Criminal Behavior			
Autism spectrum			
Schizophrenia			
Diabetes			