ADULT STRUCTURED CLINICAL INTERVIEW

Name: _____ Referred by: _____
Date: _____ DOB: _____ Age: ___ Primary Language: _____
Ethnicity: □ Caucasian □ African American □ Asian □ Hispanic □ Native American □ Other
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Living with a partner
Handedness: □ Right □ Left □ Both
Do you have any children (including natural, adopted, or step)? □ YES (boys:___ girls:___) □ NO
Did they live with you? □ YES □ NO

What is the reason for this evaluation? _____
_____
_____
_____
_____

Do you currently have any difficulties with the following (check all that apply)?

- □ Attention or concentration
- □ Memory (long-term or recent)
- □ Thinking
- □ Word finding
- □ Dizziness
- □ Coordination
- □ Taste or smell
- □ Changes in your sense of touch
- □ Seizures
- □ Severe headaches
- □ Fatigue
- □ High blood pressure
- □ Temper / impulse control
- □ Depression (i.e. sadness)
- □ Anxiety
- □ Vision (I wear glasses or contacts: □ YES □ NO)
- □ Hearing (I wear a hearing aid: □ YES □ NO)

Where were you born? _____
Where were you raised? _____
Who raised you? _____
Were there any complications during your birth? □ YES □ NO
If yes, describe: _____
Did you meet all developmental milestones (i.e. speech, walking, toilet training)? □ YES □ NO
If no, describe: _____
How many brothers and sisters (include ages) do you have, including both living and deceased?
Brothers: _____ Sisters: _____
Were the members of your family close? □ YES □ NO
Are your parents and all of your siblings still alive? □ YES □ NO

Did you or anyone else in your family ever experience abuse? □ YES □ NO
If yes, indicate what type: □ physical □ sexual □ emotional
Was physical punishment used in your family? □ YES □ NO
If yes, what was the most severe kind of punishment you received? _____
Where do you currently reside? _____
With whom? _____

Do you take medications (prescription/over the counter)? □ YES □ NO
Medications: _____
Have you ever had any medical illnesses or conditions? □ YES □ NO
Write them down: _____
Do you currently have any medical illnesses? □ YES □ NO
Write them down: _____
Have you ever experienced any of the following problems at any time:

Head injury	□ YES	□ NO
Other serious injuries	□ YES	□ NO
Surgeries	□ YES	□ NO
Loss of Consciousness	□ YES	□ NO
Seizures	□ YES	□ NO
Severe or frequent headaches/migraines	□ YES	□ NO
Allergies to food or medication	□ YES	□ NO
A learning disorder	□ YES	□ NO
Attention deficit disorder	□ YES	□ NO
Hyperactivity disorder	□ YES	□ NO
Psychiatric hospitalization	□ YES	□ NO
Neurological Problems	□ YES	□ NO
Identify: mental retardation, seizures, brain tumors, stroke, aneurysm, senility, dementia	□ YES	□ NO
Any other psychiatric diagnosis	□ YES	□ NO

Explain: _____
Have you ever had any previous psychological evaluations? □ YES □ NO
When and Why? _____
Have you ever had psychological treatment or counseling? □ YES □ NO

Have you ever had any serious problems with the following:

Consistently feeling depressed or down, most of the day, nearly every day, for at least 2 weeks?	□ YES	□ NO
Thoughts of death, dying, or things coming to an end	□ YES	□ NO
Feelings of hopelessness or helplessness	□ YES	□ NO
Feelings of wanting to harm yourself	□ YES	□ NO
Suicide attempts	□ YES	□ NO
Sleep problems	□ YES	□ NO
Significant appetite change	□ YES	□ NO
Significant weight loss or gain without trying over a short period of time	□ YES	□ NO
Prolonged problems with decreased initiative, low energy, tiredness or fatigue	□ YES	□ NO
Withdrawing from others	□ YES	□ NO
Feeling excessively angry or irritable	□ YES	□ NO
Feelings of wanting to harm others	□ YES	□ NO
Low self-esteem	□ YES	□ NO
Guilt or self-blame	□ YES	□ NO

Feeling excessively happy, dancing on air, so that others thought you were not your usual self □ YES □ NO
Racing thoughts that you did not have the ability to keep up with □ YES □ NO
Excessive energy without the need to sleep or eat □ YES □ NO
Repetitive thoughts or words that you cannot stop □ YES □ NO
Needing to repeat things over and over in your head □ YES □ NO
Excessive fear or phobia □ YES □ NO
Excessive fear about being in public places □ YES □ NO
Have you ever:
felt in danger from others? □ YES □ NO
felt that others had something personally against you? □ YES □ NO
believed you could read other people's thoughts? □ YES □ NO
had thoughts ever seemed strange, alien or confusing? □ YES □ NO
felt that you were not in control of your thoughts or actions? □ YES □ NO
seen or heard things that others could not see or hear? □ YES □ NO
smelled anything that others did not? □ YES □ NO

felt the need to cut down on your drinking? □ YES □ NO
been annoyed by people who criticize your drinking? □ YES □ NO
felt bad or guilty about your drinking? □ YES □ NO
felt the need to drink first thing in the morning to steady your nerves or get over a hangover? □ YES □ NO
had shakes, DT's, or withdrawal symptoms?
had any DUI's? □ YES □ NO
experimented with recreational or street drugs? □ YES □ NO

Are you currently feeling as though life is not worth living? □ YES □ NO
Are you thinking of harming yourself? □ YES □ NO
Do you have a plan? □ YES □ NO

Have you ever experimented with recreational or street drugs (i.e. marijuana, heroin, cocaine, etc.) □ YES □ NO
Do you smoke cigarettes □ YES □ NO How many a day? ____

Have you ever been arrested as an adult? □ YES □ NO
Have you ever been arrested as an adolescent? □ YES □ NO
Have you ever gotten into physical fights as an adult? □ YES □ NO
Have you ever gotten into physical fights as an adolescent? □ YES □ NO
Have you ever stolen anything or been arrested for shoplifting? □ YES □ NO
Have you ever owned a weapon? □ YES □ NO
Do you currently own a weapon? □ YES □ NO
Have you ever had any traffic or parking tickets? □ YES □ NO
Has your license ever been revoked or suspended? □ YES □ NO

Have you ever been on Public Assistance? □ YES □ NO

Has any close relative ever had the following problems (grandparents, parents, siblings, children):

Psychiatric hospitalization □ YES □ NO
Mental health treatment or counseling □ YES □ NO
Serious depression □ YES □ NO
Suicide attempts □ YES □ NO
Alcohol Abuse □ YES □ NO
Drug Abuse □ YES □ NO
Arrests for serious crimes □ YES □ NO
Neurological problems □ YES □ NO

Identify which: mental retardation, learning disability, hyperactivity, attention deficits, seizures, brain tumors, stroke, aneurysm, senility, or dementia

Have you or any family member been the victim of a violent or serious crime? □ YES □ NO

Explain: _____
_____
_____
_____

Total years of education you completed: _____ Highest degree achieved: _____
Grades received in: Elementary/middle school? _____ High School? _____ College? _____
While you were in school, did you, or were you ever:

drop out of school for at least a semester? □ YES □ NO
suspended/expelled/disciplined? □ YES □ NO
held back a grade? □ YES □ NO
in special education classes? □ YES □ NO
miss a month or more of school for any reason? □ YES □ NO

As a child were you ever told or diagnosed with the following:

Attention Deficit/ Hyperactivity Disorder? □ YES □ NO
Learning Disorder of any kind? □ YES □ NO

What is your current occupation? _____
Are you having any work related difficulties? □ YES □ NO
How long were you at the job you held the longest? _____
Have you ever been fired from a job for any reason? □ YES □ NO
Have you ever been suspended, reprimanded, or otherwise disciplined? □ YES □ NO
If no job, what is your source of income? _____
Have you ever served in the military? □ YES □ NO

Branch: _____ Highest Rank: _____
Suspended, reprimanded or otherwise disciplined? □ YES □ NO
Did you receive an Honorable Discharge? □ YES □ NO

Do you have any questions regarding:

□ *purpose of the evaluation*
□ *limits of confidentiality*
□ *understanding and agreement to participate*