Personal History — Adult >18

Client's Name: _____ Today's Date: _____

Gender: ___ M ___ F Date of Birth: _____ Age: _____ Employed? ___ Yes ___ No

If someone other than client, form completed by: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____) _____ Work: (____) _____ Other: (____) _____

Email: _____

Preferred method of contact: ___ Phone Call ___ Phone Text ___ Email ___ Mail ___ Other _____

Primary reason(s) for seeking services:

___ Cognitive Assessment
___ Academic Assessment
___ Full Learning Assessment

___ Visual Processing
___ Auditory Processing
___ Memory
___ Executive Functions
___ Critical Thinking
___ Social Skills
___ Other Cognitive Skills

___ Consultation Services
___ Behavior Management Plan

___ Test Prep
- ___ GED
- ___ ASVAB
- ___ Other: _____

___ Academic Therapy:
- ___ Phonics/Spelling
- ___ Vocabulary/Spelling
- ___ Reading
- ___ Penmanship
- ___ Written Expression
- ___ Grammar
- ___ Math
- ___ Research/Essay Writing
- ___ Creative Writing

___ Classes for Adults
- ___ Public Speaking
- ___ Study Skills
- ___ Time Management
- ___ Organization
- ___ Other _____

___ Classes for Seniors
- ___ Computer
- ___ IPad or Tablet
- ___ Smart Phone
- ___ Email
- ___ Facebook
- ___ Issues with Aging
- ___ Research on Alzheimers
- ___ Other _____

What are YOUR personal goals for training? _____

_____

Development Information

Childhood

Did you have a happy childhood? ___ Yes ___ No Who raised you? _____

How did you reach early childhood development markers? Later than usual About average Earlier than usual

Were there any specific issues noted from birth through age 3?

_____

Are there any special, unusual, or traumatic circumstances that affected your development? ___ Yes ___ No

If yes, please describe _____

Childhood issues: ___ Physical Abuse ___ Sexual Abuse ___ Verbal Abuse ___ Neglect ___ Inadequate Nutrition

___ Other _____ In any of these were you the: ___ Victim ___ Perpetrator

Were you ever a foster child? ___ Yes ___ No Are you adopted? ___ Yes ___ No If yes, when? _____

Comments on child development: _____

Adolescence

Were you a happy teenager? ___ Yes ___ No Did you have good relationships with your parents? ___ Yes ___ No

About what age did you hit puberty? _____ Did you have friends as a teenager? ___ Yes ___ No

Were there any specific issues noted from age 12 to 18?

_____

Are there any special, unusual, or traumatic circumstances that affected your adolescence? ___ Yes ___ No

If yes, please describe _____

Adolescent issues: ___ Physical Abuse ___ Sexual Abuse ___ Verbal Abuse ___ Neglect ___ Food Issues ___ Bullying

___ Other _____ In any of these were you the: ___ Victim ___ Perpetrator

Were you ever a foster child? ___ Yes ___ No Are you adopted? ___ Yes ___ No If yes, when? _____

Comments on adolescence: _____

Adult Life

Do you work at a job? ___ Yes ___ No If yes, what do you do? _____

Is you work satisfying? ___ Yes ___ No If not, are you interested in life coaching or career help? ___ Yes ___ No

What are your interests, hobbies,, or leisure activities? _____

Do you exercise? ___ Yes ___ No What do you do for physical exercise? _____

Do you play an instrument or sing? ___ Yes ___ No What do you play? _____

Do you play video games? ___ Yes ___ No What system(s) do you prefer? _____

Is there any other information you would like us to know about growing up, your life, your interests?

_____

Family Information

Relationship	Name	Age	Living?	Living with You?	Learning/Health Issues?
Spouse	_____	_____	**Yes No**	**Yes No**	_____
Father	_____	_____	**Yes No**	**Yes No**	_____
Mother	_____	_____	**Yes No**	**Yes No**	_____
Children	_____	_____	**Yes No**	**Yes No**	_____
	_____	_____	**Yes No**	**Yes No**	_____
Other significant relationships:					
_____	_____	_____	**Yes No**	**Yes No**	_____
_____	_____	_____	**Yes No**	**Yes No**	_____

Education Information

Years of Education _____ Currently enrolled in school? ___ Yes ___ No If yes, where? _____

Highest Level of Education: ___ Dropped out of high school ___ GED ___ High School Diploma ___ Some College

___ Bachelor Degree: Year _____ School _____ Major: _____

___ Masters Degree: Year _____ School _____ Major: _____

Other Training: Year _____ Organization _____ Program: _____

In YOUR opinion, are/were you a(n): ___ Under Achiever ___ Average Student ___ Above Average Student ___ High Achiever

What do you consider your strengths? _____

What do you consider your weaknesses? _____

Is there any other information that would help us understand your situation, concerns, or goals? ___ Yes ___ No

_____

Do your goals for cognitive training involve furthering your education? ___ Yes ___ No

Describe: _____

Feelings about School and/or Learning

___ Angry
___ Fearful
___ Anxious
___ Bored
___ Ambivalent (Neutral)
___ Other _____
___ Confident
___ Eager
___ Enthusiastic

Approach to School and/or Work

___ Refuses
___ Disorganized
___ No initiative
___ Sloppy
___ Incomplete assignments
___ Does only what is expected
___ Cooperative
___ Organized
___ Independent
___ Goes above and beyond
___ Other _____

Social Relationships

___ Difficulty making friends
___ Makes friends easily
___ Extraverted
___ Many friends
___ Socially confident
___ Leader
___ Follower
___ Introverted
___ Few friends
___ Socially awkward
___ Aggressive / Argumentative
___ Friendly / Kind
___ Social anxiety
___ Long--term, very close friends
___ Enjoys large crowds / Parties

Emotional / Behavioral Patterns

___ Affectionate
___ Aggressive
___ Always moving
___ Angry
___ Anxious
___ Argumentative
___ Avoids
___ Clumsy
___ Confused easily
___ Cooperative
___ Daydreams
___ Depressed
___ Difficulty speaking
___ Expects failure
___ Fatigues easily
___ Friendly / Kind
___ Frustrated easily
___ Generous / Helpful
___ Happy / Cheerful
___ Hypervigilant
___ Impulsive
___ Inattentive / Distracted
___ Lies / Exaggerates
___ Overly messy
___ Overly neat
___ Obsesses or Perseverates
___ Optimistic / Positive
___ Perfectionistic
___ Pessimistic / Negative
___ Submissive
___ Talks excessively
___ Tics or Twitching
___ Other _____

Military Information

Military Experience? ____ Yes ___ No Combat Experience? ___ Yes ___ No Discharge Date: _____

Branch: _____ Where: _____ Rank at Discharge: _____

Health / Learning Information

___ Allergies
___ Anxiety
___ Aphasia
___ Apraxia
___ Attention Deficit/Hyperactivity
___ Autism Spectrum Disorder
___ Autoimmune Disorder
___ Blindness
___ Central Auditory Processing Disorder
___ Cerebral Palsy
___ Deafness
___ Developmental Disorder
___ Diabetes
___ Dyslexia
___ Emotional Disorder
___ Mental Illness _____
___ Migraines
___ Low Muscle Tone
___ Perceptual Motor Disorder
___ Traumatic Brain Injury
___ Visual Processing Disorder
___ Seizures
___ Other _____

How is your overall health? ___ Excellent ___ Very Good ___ Good ___ Fair ____ Poor

Have you had a recent eye exam for acuity? ___ Yes ___ No Results? _____

Glasses? ___ Yes ___ No Contacts? ___ Yes ___ No Surgery? ___ Yes ___ No If yes, describe _____

Have you ever been seen by a vision therapist? ___ Yes ___ No Have you ever received vision therapy? ___ Yes ___ No

Have you had a recent hearing exam? ___ Yes ___ No Results? _____

Hearing aids? ___ Yes ___ No Surgery? ___ Yes ___ No If yes, describe _____

Have you ever received speech/language therapy? ___ Yes ___ No Reason? _____

Have you ever received tutoring services or academic interventions (RTI, Title I, etc)? ___ Yes ___ No

Have you ever received special education services? ___ Yes ___ No If so, how long? _____

Are you currently on any prescribed or over-the-counter medications? ___ Yes ___ No

If yes, please list medications (including OTC, dose, and condition):

_____

_____

Do you use smoke or vape? ___ Yes ___ No If yes, how often and how long? _____

Do you drink alcohol? ___ Yes ___ No If yes, how often and how long? _____

Do you use drugs, including marijuana? ___ Yes ___ No If yes, how often and how long? _____

Do you use any other chemical substance? ___ Yes ___ No If yes, how often and how long? _____

Have you ever received counseling or psychiatric treatment? ___ Yes ___ No Describe _____

Drug/Alcohol Interventions? _____

Hospitalizations? _____

Do you drive a vehicle? ___ Yes ___ No If no, reason _____

Any other issues that may help us know issues that impact your learning? _____

Policies

Attendance and Cancellations. Brighter Path wants to respect the time and needs of all of our clients, and we desire to provide the highest quality of educational services for your child. Therefore, it is important that you arrive on time or a bit early for all scheduled appointments. In cases where clients are late for scheduled appointments, the appointment will end at the scheduled time regardless of the remaining time. If you need to cancel, please call at least 24 hours in advance. Short notice may result in a partial fee for a scheduled appointment. No shows will be billed at the regular rate since we will not be able to fill that spot with other clients who may have needed that time. Drop-In cognitive training will count toward the program allotment, but requires no appointment. Drop-in training is available on a first-come, first-serve basis.

_____ _____

Client's Signature Today's Date

_____ _____

Guardian's Signature Today's Date

Confidentiality. I acknowledge that the information provided is accurate. Brighter Path holds to the highest professional ethics in both the education and psychology fields. I understand the information will be used only by the center staff for assessing, determining an appropriate cognitive and/or academic program, and implementing services. I can obtain copies of my report at any time. The information will be kept confidential and released to other providers only with a written release of information form.

_____ _____

Client's Signature Today's Date

_____ _____

Guardian's Signature Today's Date

Process and Financial Commitment. An assessment for cognitive skills, academic skills, or both will be conducted unless a previous diagnostic assessment is submitted. Payment for the assessment will be required at the time of service. Following the assessment, the results will be reported, and a program designed specifically for you will be presented. You are under no obligation to continue with our services. We offer no guarantees of results since too many factors impact learning. The cognitive training commitment will be 50 hours, extending in 10 hour increments if needed. Once a training program is started, the license fee, which is part of the package fee, is not refundable. You may withdraw at any time.

Payment for the assessment will be required at the time of service. Down payment for therapy programs are due up front and are non-refundable. The balance may be divided over the course of training. A statement will be emailed at the beginning of each month. Fees for cognitive training must be paid in full prior to starting continuation or other services. Payments accepted are credit cards, debit cards, checks, and cash. Arizona ESA funds may also be used for our services.

_____ _____

Client's Signature Today's Date

_____ _____

Guardian's Signature Today's Date