

## 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?  YES  NO
- 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*