WILLIAM A. BURKHART, PH.D., ABPN

INTAKE QUESTIONNAIRE Date Completed: _____

Name: _____ / Date of Birth: _____

If Assisted in completing this form / Name: _____

Patient Phone: _____ / Emergency Phone Contact: _____

This questionnaire is to be completed by you prior to your first appointment. Please complete as much of it as possible. If you require help from friends or family members to most accurately report dates or other information, please feel free to get that help. If you were assisted in its completion, please indicate by placing that person's name next to yours above.

The information contained in this questionnaire is confidential. As part of your file, it is subject to the limitations in confidentiality that are outlined in the Financial Disclosure and Evaluation consent forms, which you have been asked to complete as well.

The questionnaire is meant to be a starting point for discussion with Dr. Burkhart. The information that you provide will be reported to the degree that it is relevant to diagnostic conclusions and treatment suggestions. If you have any questions about confidentiality or whether or not to include certain kinds of information, feel free to speak with Dr. Burkhart about your concerns. Again, the most important goal is an understanding of the personal, social and historical context in which your current problems have developed. You are encouraged to do whatever you can to help Dr. Burkhart with that goal in mind.

If you have any questions about the content of this questionnaire or are having trouble completing it, please free to call Dr. Burkhart's office at 206-365-1435.

DIPLOMATE, AMERICAN BOARD OF PROFESSIONAL NEUROPSYCHOLOGY

neuropsychology, rehabilitation and general clinical psychology

20056 19th Ave NE / Shoreline, WA 98155
(206) 365-1435 fax (206) 365-1428

I. Please describe the major symptoms or problems, for which you are being evaluated:

Date of any open work injury claim: _____ - What happened?

Symptoms or problems, related to this claim?

Date of any open MVA injury claim: _____ - What happened?

Symptoms or problems of onset with this accident?

II. List all major medical or psychiatric diagnoses you have had and the approximate date each one was made.

a.		Approx Date:	
b.		Approx Date:	
c.		Approx Date:	
d.		Approx Date:	
e.		Approx Date:	

III. List all medications (prescription and non-prescription that you take now and the approximate date they were first prescribed.

	Name of Medication	Dosage	To Help	Approx Date
a.				
b.				
c.				
d.				
e.				

IV. List all physicians that you now see.

a.		for:	
b.		for:	
c.		for:	

V. If you ever had surgery for back, neck, or other pain problems, please fill in the following for each operation.

	Approx Date	Type of surgery and surgeon	Pain after surgery (check)		
a.			Worse ☐	Same ☐	Better ☐
b.			Worse ☐	Same ☐	Better ☐
c.			Worse ☐	Same ☐	Better ☐
d.			Worse ☐	Same ☐	Better ☐

VI. Please list any non-pain related surgeries you have had and the approximate date of each one:

a. _____ Approx Date: _____

b. _____ Approx Date: _____

VII. Starting with your most recent or current full-time employment, please list your employer's name, your job title, the number of years you were assigned, and reasons for leaving each job.

	Employer Name	Job Title	Years Assigned	Reason for Leaving
a.				
b.				
c.				
d.				

VIII.

a. If any learning disabilities or difficulties during your schooling years, describe:

b. If High School Diploma, year completed: _____

c. If no HS Diploma, highest grade completed: _____

e. Post-high school classes or degrees? If so, state what they are / where completed:

IX. How did your parents or primary caretakers relate to you, when you were growing up?

Father – positive: _____ negative: _____

Mother – positive: _____ negative: _____

Other – positive: _____ negative: _____

X: Describe your current spouse or primary partner or best friend(s):

XI. Place an "X" to indicate whether the following pertains to or have ever pertained to your parents, siblings, yourself, your significant other, or your children.

	Parents	Sibling	Self	S.O.	Children
Neurological Illness	☐	☐	☐	☐	☐
Alcohol abuse	☐	☐	☐	☐	☐
Work disability	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Marijuana use	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Near drowning	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐
Assault victim	☐	☐	☐	☐	☐
Electrocution	☐	☐	☐	☐	☐
Loss of consciousness	☐	☐	☐	☐	☐
Head trauma	☐	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐	☐
Psychiatric hospitalization	☐	☐	☐	☐	☐
Poor anger control	☐	☐	☐	☐	☐
Antisocial behavior	☐	☐	☐	☐	☐
Arrests/convictions	☐	☐	☐	☐	☐
Industrial injury	☐	☐	☐	☐	☐
Motor vehicle accident	☐	☐	☐	☐	☐
Injury-related litigation	☐	☐	☐	☐	☐
Learning disability	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Abuse victim	☐	☐	☐	☐	☐

XII. Place an "X" to indicate whether any of the following events or situations occurred in your life less than one year ago, less than 5 years ago, more than 5 years ago, or never.

	Less than 1 Year ago	Less than 5 Years ago	More than 5 Years ago	Never Occurred
Death of a child	☐	☐	☐	☐
Death of parent(s)	☐	☐	☐	☐
Birth of child	☐	☐	☐	☐
Miscarriage	☐	☐	☐	☐
Retirement	☐	☐	☐	☐
Divorce	☐	☐	☐	☐
Recreational accident	☐	☐	☐	☐
Excessive work hours	☐	☐	☐	☐
Personal trauma	☐	☐	☐	☐
Start of school	☐	☐	☐	☐
Job loss	☐	☐	☐	☐
Family illness	☐	☐	☐	☐
Relationship conflict	☐	☐	☐	☐
Parenting conflict	☐	☐	☐	☐
School failure	☐	☐	☐	☐
Child leaving home	☐	☐	☐	☐
Assault or rape	☐	☐	☐	☐
Financial crisis	☐	☐	☐	☐
Trouble with boss	☐	☐	☐	☐
Unwanted pregnancy	☐	☐	☐	☐
Loss of significant other	☐	☐	☐	☐