

# The Family Psychologist



## Adult Pre-Assessment Questionnaire- WCC ASC Screening

To help us obtain a full picture of the difficulties you have been experiencing, it is important to have some background knowledge. Please complete this questionnaire as fully as you are able and return it to us at your earliest convenience by either post or email.

### Personal Information

First name (s)		Surname	
Contact Number		Address	
Mobile Number			
Job Title			
How old are you?		Postcode	
Date of Birth		Email Address	
NHS Number		Ethnicity	
Preferred method of contact	<input type="checkbox"/> Email <input type="checkbox"/> Tel <input type="checkbox"/> Text <input type="checkbox"/> Letter		

GP Name and Address

Next of Kin (for Emergency contact only) Name and Address:

### Current difficulties

Please detail any existing diagnosis you may have:

Please describe the current difficulties that you are having, and state what impact they are having on your everyday life.

### Your Personal History and Health

If you can remember, please tell us when:

You started to crawl :    Early      On time      Late  
You started to walk :    Early      On time      Late  
You started to talk :    Early      On time      Late

Have you ever had a problem with any of the following? If so, please state how old you were, and whether you had any support for this:

- Speech
- hearing
- eyesight
- reading/ writing/ spelling
- numbers
- coordination

Please provide details of any serious illnesses, accidents or head injuries that you have had, and what age you were when you had them:

Do you take regular medication, and if so what for?

Have you ever suffered from depression?

Do you have any sensory difficulties that you are aware of? (such as disliking certain sounds, textures or smells).

## **Your Education**

What qualifications do you have (please give marks or grades?)

Did you have any difficulties at school? If so, please describe these:

Did your school give you any help with your problems?      Yes / No

If Yes, what help?

## **Your Family**

In your **whole family** (including e.g. uncle, grandparents), does anyone suffer with the following problems, and if so, who?

*Reading*

*Writing*

*Spelling*

*Numbers*

*Remembering things*

*Depression*

*Anxiety/ worrying*

*Hearing*

*Autism*

*Dyslexia/Dyscalculia/ Dyspraxia*

## **Current education**

Are you currently studying at college/university now?      Yes / No

If Yes, **what** are you studying?

**where** are you studying?

**what year** are you in?

What are the worst problems about being a student at college/university?

What help do you get from your college/university (if any)?

## **Current Occupation**

Do you have a job at the moment?  
If so, what do you do?

Have you had a job in the past?

How have your current difficulties affected how you do your job(s)?

## **Interests/hobbies**

Do you have any special interests or hobbies that you enjoy doing? If so, please describe these here:

Please read the statement and decide if it is True or False. Please tick appropriate box.

Question	True all the time	Sometimes True	False
Fearful of movement e.g. escalators, theme park rides			
Likes to play contact sports			
Always on the move			
Is heavy footed			
Dislikes certain fabric clothing e.g. denim			
Often fiddles with objects			
Strongly dislikes grooming activities e.g. hair washing, nail trimming, teeth cleaning			
Is bothered by flickering lights			
Fussy eater, only likes certain textures of food			
Easily distracted by noise, e.g ticking of a clock			
Clumsy and awkward in movements			
Has poor balance			
Poor handwriting			
Disorganised with belongings			
Becomes easily frustrated			
Needs to practise new movement activities that other people learn more easily e.g. in an aerobics class			
Difficulty with self-care skills e.g. dressing, using a knife and fork			

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Signed: \_\_\_\_\_

**Your information will be stored securely and only shared with professionals involved in your assessments, therapy or your GP. Parents must sign the form if you are under 18.**

## Form Return Details

Please return the completed form to:

**The Family Psychologist Ltd**

11 Church Street

Kidderminster

DY10 2AH

By email to: [support@thefamilypsychologist.co.uk](mailto:support@thefamilypsychologist.co.uk)

Or fax it to: **01562 61 00 16**