



SEVENBRIDGES THERAPY

Adult Services Questionnaire (18 & over)

Date: _____

Person Completing Form: _____

Relation to Client (if applicable): _____

Client First/Last Name: _____

Age: _____ DOB: _____ Gender: Male Female

Address: _____ City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Referred By: _____

Preferred method of contact: Phone Cell Phone Work Phone Email

Contact person: _____ Relationship: _____

Contact Person's Phone Number: _____ Contact person's email: _____

Personal Information:

I am: Single In a relationship Married Divorced Widowed # of years: _____

I live: With my parents Independently Other, please explain: _____

I am responsible for my own expenses: Yes No

Employment History:

Current Employer: _____ Full Time Part Time

Occupation/Job Title: _____ Hours worked in a week: _____

How do you feel you are doing at work? Excellent Satisfactory Poor

Please describe any current concerns you have regarding your employment: _____

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Educational History:

I am currently attending school at: _____ Full Time Part Time

General class schedule: _____

Major: _____

Highest level of education completed: High School Junior College College/University Trade

Degree(s): _____

Please describe any current concerns you have regarding your schooling: _____

Is there someone at school we may contact: Yes No

Name, Title: _____

Telephone, Email address: _____

Current Services:

Describe your major concerns regarding yourself (be specific): _____

Doctor/Specialist: _____ Last Seen: _____

Speech Language Pathology Services (therapist/frequency):

Goals/needs being addressed:

Psychological Services (therapist/frequency):

Goals/needs being addressed:

Other Support Services: _____

Medical History & Information: (Please check all that apply)

Chronic Colds/Respiratory Infections Temporary Hearing Loss Asthma

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Chronic Ear Infections

Hearing Impairment

Allergies

Cerebral Palsy

Attention Deficit Disorder

High Fever

Head Trauma

Eye Problems

Tonsillitis

Diagnosis (if any): _____

If you are currently taking any medication please list: _____

If you are currently on any special diet or dietary restrictions, please describe: _____

Do you have any other medical conditions we need to be aware of? _____

Social / Speech / Language History:

What is your main reason for contacting us? _____

Please list strengths and challenges you have that are **relevant** to the Occupational, Speech & Language, Self-Regulation, and Social Communication areas.

Strengths: _____

Challenges: _____

Please list three **goals** you have for yourself that are **relevant** to the Occupational, Speech & Language, Self-Regulation, and Social Communication areas.

1. _____

2. _____

3. _____

What are some of your **interests/activities/hobbies**?

Additional concerns and/or comments: _____

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In order to provide our therapists with a complete profile of your strengths and challenges, please check any areas you feel apply:

Social Learning:

Please rate: G=Good F=Fair P=Poor
____ Conversation ____ Eye Contact ____ Greetings
____ Organization ____ Team Work/Group Projects

Are you comfortable working with a group of 3-4 people without assistance?

Yes No

Social Communication/Cognitive Skills:

- Avoids or is not interested in social interactions with peers, classmates, and/or co-workers.
- Needs to be directly taught "implied social rules," such as keeping personal space, responding to others when they talk to or greet me, and how to talk to authority figures vs. peers.
- Has difficulty problem solving and generating effective solutions independently.
- Has trouble looking at people when talking or listening.
- Has trouble understanding facial expressions, gestures, or body language.
- Has difficulty understanding another's perspective (point of view).
- Has difficulty initiating interactions or asking for help.
- Interprets language more literally than others do / have difficulty understanding expressions, such as "It's raining cats and dogs".
- Does not tell enough background information for the listener to understand my story.
- Tends to interrupt others when speaking.
- Gets in frequent conflicts with peers.
- Overreacts to various social situations.
- Has anxiety in many situations.

Speaking/Expressive Language:

- Has trouble answering questions people ask / take longer to answer questions.
- Has trouble asking questions.
- Has trouble using a variety of vocabulary words when talking.
- Has trouble expressing/organizing some thoughts.

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- Has trouble getting to the point when talking / give too many irrelevant details.
- Has trouble putting events in the right order when telling stories or talking about things that happened.
- Uses poor grammar when talking.
- Has trouble using complete sentences when talking.
- Has trouble expanding an answer or providing details when talking.
- Often blurts out answers before the question has been completed.
- Knows the word I want to say, but cannot think of it.
- Makes false starts and revisions when relating an experience (e.g., “we were... Bob and I went to the game.”).
- Uses time fillers when trying to think of a word (e.g., um...er...um...computer).

Auditory Processing/Listening/Receptive Language:

- Often needs directions repeated and/or has trouble following spoken directions.
- Needs extra time to respond to questions.
- Background noise makes following verbal instructions even more difficult.
- Says “huh” or “what” in response to questions.
- Has trouble remembering things people say.
- Has to ask people to repeat what they have said.
- Has trouble understanding the meaning of words.

Attention:

- Has trouble sustaining attention in tasks or social activities in school, work, or at home.
- Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or in other activities.
- Often loses things necessary for tasks and activities (e.g., school assignments, pencils, books, or tools).
- Leaves seat in the classroom, office, or in other situations in which remaining seated is expected.
- Easily distracted.
- Has difficulty waiting for turn.
- Daydreams or is inattentive/loses focus easily.

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Reading:

- Has trouble understanding what was read.
- Has trouble explaining what was read.
- Has trouble identifying the main idea.
- Has trouble remembering details.
- Has trouble following written directions.

Writing:

- Has trouble writing down thoughts.
- Has poor grammar when writing.
- Has trouble writing complete sentences.
- Has trouble expanding an answer or providing details when writing.
- Has trouble putting words in the right order when writing sentences.
- Has trouble getting started on a writing assignment.

Executive Functioning Skills

- Often does not learn from past experiences.
- Perseverative, has difficulty initiating or inhibiting a shift in behavior or thought.
- Has trouble previewing: foreseeing possible problems or conflicts.
- Has difficulty participating in family routines and responsibilities.
- Has difficulty maintaining composure during unstructured time.
- Has difficulty envisioning a goal or outcome.
- Has difficulty making and following a plan to achieve a desired outcome.
- Has difficulty overestimating/underestimating their abilities and skills.

Scheduling Availability

A great deal of time and consideration is put into pairing our group members with the appropriate group to match age, development, and therapeutic needs. We juggle multiple schedules in order to find an available time slot that works for all. Therefore, please allow us as much flexibility as you can in order to make this happen.

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Indicate the times you are available to participate in therapy by writing in the boxes provided.

Monday

9am – 7pm

Tuesday

9am – 7pm

Wednesday

9am – 7pm

Thursday

9am – 7pm

Friday

9am – 7pm

Saturday

9am – 4pm