

**PAUL M. DEUTSCH & ASSOCIATES, P.A.**  
**CLINICAL INTERVIEW AND HISTORY**

Counselor:

Accompanied By:

Telephone Pre-Evaluation:

Date of Evaluation:

Evaluation Location:

Re-Evaluation Date:

Name  Social Security #  Phone

Cell Phone  Fax  E-Mail

Address  City  State  Zip

County  Closest Metro Area

Birthdate  Age  Date of Onset  Marital Status

Birthplace  Citizen  Race  Sex

Elementary/Secondary Education

Employer/School  Position/Grade

Bilingual  Glasses  Dominant Hand

Height  Weight (present)  Weight (pre-injury)

How Injured?

Loss of Consciousness or Altered State of Consciousness:

Length of Unconsciousness or of Altered State:

Independent Recall

Client Name:

Eval Date

**Rehabilitation Program(s) [In/Outpatient Since Injury]**

**Prior Medical History:**

**Chief Complaint(s)**

**Current Disability**

**Disabling Problems:**

**Client Name:**

**2**

**Eval Date**

**Anticipated Treatments:**

	↑
	↓

**Patient:**

**Psychosocial Issues**

	↑
	↓

**Family:**

	↑
	↓

**Physical Limitations**

**Loss of Tactile Sensation**

	↑
	↓

**Reach**

	↑
	↓

**Lift**

	↑
	↓

**Prehensile/Grip**

	↑
	↓

**Sitting**

	↑
	↓

**Client Name:**

3

**Eval Date**

**Stand**

	↑
	↓

**Walking/Gait**

	↑
	↓

**Bend/Twist**

	↑
	↓

**Kneel**

	↑
	↓

**Stoop/Squat**

	↑
	↓

**Climb**

	↑
	↓

**Balance**

	↑
	↓

**Breathing**

	↑
	↓

**Headaches**

	↑
	↓

**Vision**

	↑
	↓

**Hearing**

	↑
	↓

**Driving**

	↑
	↓

Physical Stamina (average daily need for rest or reclining)

  

### Environmental Influences

Air Conditioning

Heat

Cold

Wet/Humid

Sudden Changes

Fumes

Noise

Stress

Other:

  

### Activities Of Daily Living

Sleep Pattern:

Arises  Retires  Average Hours Sleep/24 Hours

Sleep Difficulties

  

Dressing:

Independence In:

Housework/Home Maintenance

Cooking

Laundry

Yard Work

### Social Activities

Client Name:  5 Eval Date

**Organizations Pre/Post:**

Empty text box with scroll bar

**Volunteer Work Pre/Post**

Empty text box with scroll bar

**Socialization Pre/Post:**

Empty text box with scroll bar

**Hobbies (Present)**

Empty text box with scroll bar

**Hobbies (Previous)**

Empty text box with scroll bar

**Personal Habits**

**Smoking**

Empty text box

**Alcohol**

Empty text box

**Drugs**

Empty text box

**History of Abuse and/or Treatment Programs**

Empty text box with scroll bar

**Socioeconomic Status**

Spouse  Spouse Age  Occupation

First Marriage  Children

Number in Residence

Type of Residence

Client Name:  6 Eval Date

## Income:

Disability Policy	\$	<input type="text"/>
V.A.	\$	<input type="text"/>
W.C.	\$	<input type="text"/>
D.V.R.	\$	<input type="text"/>
S.S.D.I.	\$	<input type="text"/>
S.S.I.	\$	<input type="text"/>
S.S. Retirement	\$	<input type="text"/>
Wages	\$	<input type="text"/>
Food Stamps	\$	<input type="text"/>
Other Income		<input type="text"/>
Medicaid		<input type="text"/>
Medicare		<input type="text"/>

### Current Financial Situation

## Other Agency Involvement

State Voc Rehabilitation	<input type="text"/>
State Employment Svc.	<input type="text"/>
Rehabilitation Nurse	<input type="text"/>
Other Agency	<input type="text"/>
Felony Convictions?	<input type="text"/>

## Education & Training

Highest Grade Completed	<input type="text"/>
Last School Attended	<input type="text"/>
Trade/Tech Training	<input type="text"/>
Apprenticeship/OJT	<input type="text"/>
Other Education	<input type="text"/>
Literacy	<input type="text"/>
Licenses/Certifications	<input type="text"/>

### Misc Education Info

Client Name:

7

Eval Date

**Military Experience**

Branch   
Service Dates   
Discharge   
Service Disability   
Rank/Duties   
Training

**Employment History**

Released to Return to Work

Work History Since Injury

Employer  City/State   
Position   
Start Date  End Date  Schedule   
Length  Wage   
Duties   
Reason for Leaving

Employer  City/State   
Position   
Start Date  End Date  Schedule   
Length  Wage   
Duties

Reason for Leaving

Client Name:  8 Eval Date



Employer  City/State   
Position   
Start Date  End Date  Schedule   
Length  Wage   
Duties   
Reason for Leaving

Employer  City/State   
Position   
Start Date  End Date  Schedule   
Length  Wage   
Duties   
Reason for Leaving

Employer  City/State   
Position   
Start Date  End Date  Schedule   
Length  Wage   
Duties   
Reason for Leaving

**Other Work Experience**

**Observations**

Orientation   
Stream of Thought   
Approach   
Attitudes/Insight   
Appearance:

**Tests Administered**

Client Name:  9 Eval Date

- |  |   |   |                                 |
|--|---|---|---------------------------------|
| <input type="checkbox"/> Adaptive Behavior | <input type="checkbox"/> Bayley                 | <input type="checkbox"/> Hawaii Charts                      | <input type="checkbox"/> MMPI-1 |
| <input type="checkbox"/> Wahler/Whiteley   | <input type="checkbox"/> Vineland               | <input type="checkbox"/> GED Locator                        |                                 |
| <input type="checkbox"/> Wahler            | <input type="checkbox"/> Locke-Wallace          | <input type="checkbox"/> Adolescent Problem                 |                                 |
| <input type="checkbox"/> Whiteley          | <input type="checkbox"/> WRAT                   | <input type="checkbox"/> Strong Campbell Interest           |                                 |
| <input type="checkbox"/> Beck              | <input type="checkbox"/> WAIS                   | <input type="checkbox"/> Strong Campbell Work Values        |                                 |
| <input type="checkbox"/> Beck Depression   | <input type="checkbox"/> Mullen Scales          | <input type="checkbox"/> Family Environment Scale           |                                 |
| <input type="checkbox"/> Beck Anxiety      | <input type="checkbox"/> Booklet Category       | <input type="checkbox"/> MMPI-A                             |                                 |
| <input type="checkbox"/> Beck Suicide      | <input type="checkbox"/> Child Manifest Anxiety | <input type="checkbox"/> TABE                               |                                 |
| <input type="checkbox"/> Beck Hopelessness | <input type="checkbox"/> CDI - Child Depression | <input type="checkbox"/> 16 PF                              |                                 |
| <input type="checkbox"/> Beck Youth        | <input type="checkbox"/> PPVT - Peabody         | <input type="checkbox"/> HSPQ                               |                                 |
| <input type="checkbox"/> SIT-R             | <input type="checkbox"/> Gilmore Oral Reading   | <input type="checkbox"/> HDI                                |                                 |
| <input type="checkbox"/> MMPI-2            | <input type="checkbox"/> Slosson Drawing        | <input type="checkbox"/> Children Personality Questionnaire |                                 |

**Other Tests**

**Comments**

Release of Information