

Name and address of family physician:



# Adult Medical / Developmental History Form

This questionnaire should take approximately 20 minutes to complete. Any data collected will be kept confidential. Please complete *to the best of your knowledge*, be ready to answer all questions as thoughtfully and accurately *as possible*.

Contact Information Date of Completion:		
Name:		Preferred Pronouns:
Date of Birth:		Age:
Place of Birth:		Where did you grow up?
Home Address:		
Where can a message be left:		
Phone:	Email:	Other:
Emergency Contact:	Relationship:	Phone/email:
	reducionship.	Filone/eman.
Presenting Circumstance Reason for Referral		r none/email.

What important events, if any, hap	pened at about the same time that y	our challenges began?
Family Background —		
Relationship Status:  Single  Committed / Common-law  Married	<ul><li>Separated</li><li>Divorced</li><li>Widowed</li></ul>	
Below list all of the people <u>with w</u> partner, son, sister, adopted brothe	thom you are currently living and the r, etc.).	eir relationship to you (e.g.,
Name	Age	Relationship to you
Pregnancy (of mother)		
Duration of pregnancy ( <i>if known</i> - weeks)	Mother's age at	time of pregnancy:
Select one:  O Pre-term (under 36 weeks)	O Full-term (37-42 weeks)	O Post-term (42+ weeks)





Check any of the follo have the information:	wing proble	ms that occurred d	luring the pregnan	cy with you, provided you
☐ Drinking			How much? (app	rox.)
☐ Smoking			How much? (app	rox.)
☐ Drug use			Which? (if know	n)
Surgeries during pregi	nancy? O Ye	es O No		
Please specify:				
Other illnesses during	mother's pre	egnancy:		
S	·			
Madination to book down	· 4] ?-			
Medications taken dur	ang motner s	s pregnancy:		
Other significant even	ts, complicat	tions, or diagnostic	c procedures? Plea	ase explain.
Delivery ——				
_				
Labour: O Spontaneous		O Induced		
•				
Delivery:  O Vaginal		O Breech		O C-Section
Dirth waight	(:f1)			
Birth weight:	(if known)			
Select one:  O Underweight		O Normal weigh	nt	Overweight



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Complications		
☐ Cord around neck ☐ Hemorrhage ☐ Cyanosis ☐ Forceps	☐ Bruising ☐ Oxygen deprivatior ☐ Birth injury ☐ Required oxygen	☐ Transfusions ☐ Treatment for jaundice
Other complications?		
Specialized care (incubator, oxyge	n, NICU, etc.)	
What is known about your behavio	our, mood, and temperament for the	first 2 years of life?
Who was your main caretaker as a	n infant?	
Did you have any early medical pr	oblems? O Yes O No	
If yes, please describe:		
<b>Developmental Progress</b>	ion	
Were there any delays in your deve	elopment? Check all that apply.	
☐ Motor development (e.g., craw ☐ Language developmen (i.e., u	wling, walking, using scissors, print sing words, sentences)	ing)
If yes, please explain:		





### **Developmental milestones**

Milestones	Significant delay	Somewhat delayed	Normal rang	e Unknown
First words Sentences Walking Toilet Trained Feed self independent Button and unbutton of Dress self independen Tied own shoelaces	othes 🗌			
Additional information	on on developmental r	nilestones:		
Were any of the follo	owing present to an <b>un</b>	<b>usual</b> degree dur	ing the <b>first 6 ye</b> a	ars of life?
Please check those th	nat apply and explain a	s necessary:		
Allergies Colic Ear infections Tubes (ear infect Eating problems Poor weight gain Drooling Clumsy High fevers	Restless	Night   Night	easily calmed atmares/terrors cult to console ly agitated sually active ability esponsive everything ormal height	Abnormal weight Bedwetting Unusual fears Stuttering Difficulty speaking Sleepwalking Nail biting Climbing
Other:				
Please explain any of	f these problems:			
Are you:  O Right-handed	○ Lef	t-handed	O A	mbidextrous



Have any of your <b>siblings</b> experienced problems of O Yes	development or mastery skills?		
Please explain:			
As a child, how did your parents reward you?			
As a child, how did your parents discipline you?			
Family History			
Mother's Name			
Living? (y/n)	Age (or age at time of death)		
Highest level of education:	Occupation:		
Learning challenges:	Behavioural/mood issues:		
Have any of your maternal blood relatives experienced problems similar to those you are currently experiencing? If so, please describe:			
Father's Name			
Living? (y/n)	Age (or age at time of death)		
Highest level of education:	Occupation:		
Learning challenges:	Behavioural/mood issues:		
Have any of your paternal blood relatives experience experiencing? If so, please describe:	ed problems similar to those you are currently		





Please list all of your siblings below.

Name	Age	Learning/Emotional Difficulties
Do vou bovo ony relativos viho ov	novioused any of the following?	(check all that apply and the
Do you have any relatives who exprelation to you, e.g., uncle, cousin,		(Check all that apply and the
Togue	Matamalaida	Datamal aida
<u>Issue</u> ☐ Learning problems	<u>Maternal side</u>	<u>Paternal side</u>
Attention / concentration		
Autism		
Anxiety		
Obsessive compulsive		
☐ Depression ☐ Drug/alcohol abuse		
Intellectual disability		
Schizophrenia		
☐ Bipolar disorder		
Other (please describe):		
other (preuse describe).		
Madical History		
Medical History ———		
Have you ever had a seizure? O	∕es ○ No	
If yes, O with fever? O without		
Have you ever had a head injury, f	ainted, or lost consciousness?	Yes O No
If yes, please explain:		
v · 1 1		
A may gaying and a sale		
Any surgeries?		



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Current Medications	Dosage	Reason Prescribed	Side Effects
	ny current concerns or pas es, please describe:	t history of <b>anemia</b> or <b>thy</b>	roid dysfunction?
Do you smoke? O Yes	○ No		
If yes, how much?			
Have you quit smoking?	○ Yes ○ No		
If yes, when did you stop	?		
How much alcohol do yo	ou drink?		
Have you ever been treate	ed for problems related to	alcohol use? O Yes	) No
If yes, when?			
Do you or have you ever	used recreational drugs (i	ncluding marijuana) regul	arly? 🔿 Yes 🔘 No
If yes, which ones?			





Have you experienced any of the following? (check	all that apply)
Abuse (physical, emotional, sexual)	Alcohol or drug abuse by partner or relative
Sexual assault	Serious illness or disability in someone close
Death of someone close to you	Other possible traumatic experiences:
Please provide more context:	
All adults exhibit, to some degree, the behaviours lis exhibit to an excessive or exaggerated degree compa	
Behavioural:	Cognitive:
Hyperactivity	Tics / twitching
Sudden acts of aggression	Sleep issues / sleepwalking
☐ Impulsivity	Uncoordinated / clumsiness
☐ Risk taking	Reading / writing difficulty
Irritability	☐ Not listening
Acting as if "driven by a motor"	Poor memory
☐ Interrupting frequently	☐ Not thinking logically
☐ Temper outbursts	Problems not understanding jokes
Disorganized / erratic spending	Problems finding the right word/speech
Accident prone	Poor awareness of time
☐ Nail biting	Poor attention / concentration
Weakness	Problems expressing thoughts or ideas
☐ Energy level	Difficulty finishing tasks
Anxiety	☐ Difficulty listening
Aggression / anger	Problems expressing emotion
Depression	☐ Not learning from mistakes/experiences
Social withdrawal	Getting lost easily / poor direction
Pain	Ask for repetitions often
Other:	Other:

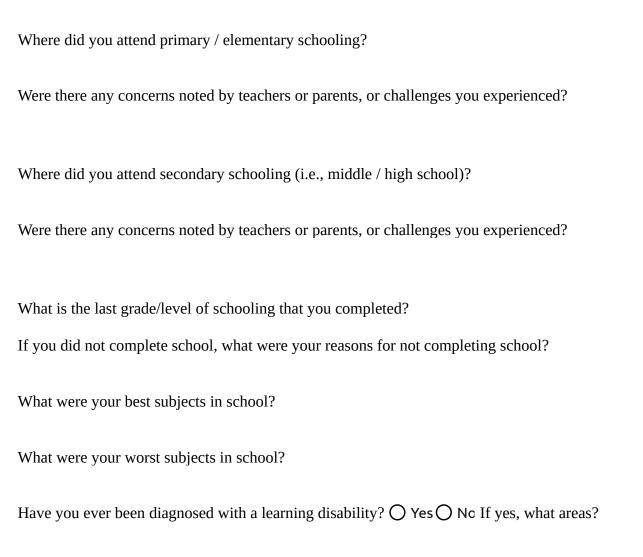


## **Mental Health History**

Have you sough	nt mental l	nealth tre	eatment	(includir	ng hospi	talizatio	on) before?		
If yes, please list the professional, reasons for treatment, and dates seen.									
Name of Health Professional		Reasons for Treatment				Dates S	Seen (approx.)		
Have you ever had psychological testing completed? If so, when and by whom?									
What were the findings and/or resulting diagnoses, if any?									
Please list all of the doctors, therapists, and other providers treating you now.									
Name			Specialty						
Please rate the amount of stress you are currently experiencing.									
	Little						Extreme		
At home: At work: With family: With friends: With neighbours:	Or none O 1 O 1 O 1 O 1 O 1 O 1	O 2 O 2 O 2 O 2 O 2	<ul><li>3</li><li>3</li><li>3</li><li>3</li><li>3</li><li>3</li></ul>		<ul><li>5</li><li>5</li><li>5</li><li>5</li><li>5</li><li>5</li></ul>	<ul><li>6</li><li>6</li><li>6</li><li>6</li><li>6</li><li>6</li></ul>	<ul><li>7</li><li>7</li><li>7</li><li>7</li><li>7</li><li>7</li></ul>	O N/A O N/A O N/A O N/A O N/A	



#### **Educational Information**



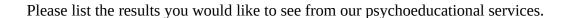


# Occupational Information \_\_\_\_\_

Are you currently working? O YesO No If yes, what are you doing?
What kinds of jobs have you held in the past? How did you feel about them?
If you have left any jobs or changed positions, what were the reasons?
What kind of work do you hope to do in the future?
Have you ever been involved with the criminal justice system?
Are you currently involved in any lawsuits or legal actions?
Personal Information
How do you enjoy spending your time?
Please list the leisure activities that you most enjoy.
Special abilities/interests
What do you see as your strengths?







Please add any other information that you feel is important for understanding both yourself and your particular situation:

Thank you.

Please submit this form via e-mail to info@talknthrive.com or

through Secured Messaging.