Talk &Thrive

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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:

Presenting Circumstances

Reason for Referral

How long ago did your problem(s) begin?

Name and address of family physician:

What important events, if any, happened at about the same time that your challenges began?

Family Background

Relationship Status:

○ Single	○ Separated
○ Committed / Common-law	○ Divorced
○ Married	○ Widowed

Below list all of the people with whom you are currently living and their relationship to you (e.g., partner, son, sister, adopted brother, etc.).

Name	Age	Relationship to you

Pregnancy (of mother)

Duration of pregnancy (*if known* - weeks)

Mother's age at time of pregnancy:

Select one:

○ Pre-term (under 36 weeks) ○ Full-term (37-42 weeks) ○ Post-term (42+ weeks)

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Check any of the following problems that occurred during the pregnancy *with you*, provided you have the information:

☐ Drinking — How much? (approx.)
☐ Smoking — How much? (approx.)
☐ Drug use — Which? (if known)

Surgeries during pregnancy? ○ Yes ○ No

Please specify:

Other illnesses during mother's pregnancy:

Medications taken during mother's pregnancy:

Other significant events, complications, or diagnostic procedures? Please explain.

Delivery

Labour:
○ Spontaneous ○ Induced

Delivery:
○ Vaginal ○ Breech ○ C-Section

Birth weight: *(if known)*

Select one:
○ Underweight ○ Normal weight ○ Overweight

Complications

- ☐ Cord around neck
- ☐ Hemorrhage
- ☐ Cyanosis
- ☐ Forceps
- ☐ Bruising
- ☐ Oxygen deprivatior
- ☐ Birth injury
- ☐ Required oxygen
- ☐ Transfusions
- ☐ Treatment for jaundice

Other complications?

Specialized care (incubator, oxygen, NICU, etc.)

What is known about your behaviour, mood, and temperament for the first 2 years of life?

Who was your main caretaker as an infant?

Did you have any early medical problems? ◯ Yes ◯ No

If yes, please describe:

Developmental Progression

Were there any delays in your development? Check all that apply.

- ☐ Motor development (e.g., crawling, walking, using scissors, printing)
- ☐ Language developmen (i.e., using words, sentences)

If yes, please explain:

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Developmental milestones

Milestones	Significant delay	Somewhat delayed	Normal range	Unknown
First words	☐	☐	☐	☐
Sentences	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Toilet Trained	☐	☐	☐	☐
Feed self independently	☐	☐	☐	☐
Button and unbutton clothes	☐	☐	☐	☐
Dress self independently	☐	☐	☐	☐
Tied own shoelaces	☐	☐	☐	☐

Additional information on developmental milestones:

Were any of the following present to an **unusual** degree during the **first 6 years** of life?

Please check those that apply and explain as necessary:

- ☐ Allergies
- ☐ Colic
- ☐ Ear infections
- ☐ Tubes (ear infection:
- ☐ Eating problems
- ☐ Poor weight gain
- ☐ Drooling
- ☐ Clumsy
- ☐ High fevers
- ☐ Headaches
- ☐ Lethargic
- ☐ Number of accident:
- ☐ Head banging
- ☐ Restless
- ☐ Aggressive
- ☐ Poisoning / exposur
- ☐ Disrupted sleep
- ☐ Thumb sucking
- ☐ Not easily calmed
- ☐ Nightmares/terrors
- ☐ Difficult to console
- ☐ Easily agitated
- ☐ Unusually active
- ☐ Irritability
- ☐ Unresponsive
- ☐ Into everything
- ☐ Abnormal height
- ☐ Abnormal weight
- ☐ Bedwetting
- ☐ Unusual fears
- ☐ Stuttering
- ☐ Difficulty speaking
- ☐ Sleepwalking
- ☐ Nail biting
- ☐ Climbing

Other:

Please explain any of these problems:

Are you:

○ Right-handed ○ Left-handed ○ Ambidextrous

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Have any of your **siblings** experienced problems of development or mastery skills?

◯ Yes ◯ No

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 experienced problems similar to those you are currently experiencing? If so, please describe:

Please list all of your siblings below.

Name	Age	Learning/Emotional Difficulties

Do you have any relatives who experienced any of the following? (check all that apply and the relation to you, e.g., uncle, cousin, grandmother, etc.)

Issue	Maternal side	Paternal side
☐ Learning problems		
☐ Attention / concentration		
☐ Autism		
☐ Anxiety		
☐ Obsessive compulsive		
☐ Depression		
☐ Drug/alcohol abuse		
☐ Intellectual disability		
☐ Schizophrenia		
☐ Bipolar disorder		

Other (please describe):

Medical History

Have you ever had a seizure? ◯ Yes ◯ No
If yes, ◯ with fever? ◯ without fever?

Have you ever had a head injury, fainted, or lost consciousness? ◯ Yes ◯ No

If yes, please explain:

Any surgeries?

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Hospitalizations?

Current Medications	Dosage	Reason Prescribed	Side Effects

Do you or your family any current concerns or past history of **anemia** or **thyroid dysfunction**?
○ Yes ○ No If yes, please describe:

Do you smoke? ○ Yes ○ No

If yes, how much?

Have you quit smoking? ○ Yes ○ No

If yes, when did you stop?

How much alcohol do you drink?

Have you ever been treated for problems related to alcohol use? ○ Yes ○ No

If yes, when?

Do you or have you ever used recreational drugs (including marijuana) regularly? ○ Yes ○ No

If yes, which ones?

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Have you experienced any of the following? (check all that apply)

- ☐ Abuse (physical, emotional, sexual)
- ☐ Sexual assault
- ☐ Death of someone close to you
- ☐ Alcohol or drug abuse by partner or relative
- ☐ Serious illness or disability in someone close
- ☐ Other possible traumatic experiences:

Please provide more context:

All adults exhibit, to some degree, the behaviours listed below. Check those that you believe you exhibit to an excessive or exaggerated degree compared to others of the same age:

Behavioural:

- ☐ Hyperactivity
- ☐ Sudden acts of aggression
- ☐ Impulsivity
- ☐ Risk taking
- ☐ Irritability
- ☐ Acting as if "driven by a motor"
- ☐ Interrupting frequently
- ☐ Temper outbursts
- ☐ Disorganized / erratic spending
- ☐ Accident prone
- ☐ Nail biting
- ☐ Weakness
- ☐ Energy level
- ☐ Anxiety
- ☐ Aggression / anger
- ☐ Depression
- ☐ Social withdrawal
- ☐ Pain

Other:

Cognitive:

- ☐ Tics / twitching
- ☐ Sleep issues / sleepwalking
- ☐ Uncoordinated / clumsiness
- ☐ Reading / writing difficulty
- ☐ Not listening
- ☐ Poor memory
- ☐ Not thinking logically
- ☐ Problems not understanding jokes
- ☐ Problems finding the right word/speech
- ☐ Poor awareness of time
- ☐ Poor attention / concentration
- ☐ Problems expressing thoughts or ideas
- ☐ Difficulty finishing tasks
- ☐ Difficulty listening
- ☐ Problems expressing emotion
- ☐ Not learning from mistakes/experiences
- ☐ Getting lost easily / poor direction
- ☐ Ask for repetitions often

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Mental Health History

Have you sought mental health treatment (including hospitalization) before?
◯ Yes ◯ No

If yes, please list the professional, reasons for treatment, and dates seen.

Name of Health Professional	Reasons for Treatment	Dates 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 or none						Extreme	
At home:	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ N/A
At work:	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ N/A
With family:	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ N/A
With friends:	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ N/A
With neighbours:	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ N/A

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Educational Information

Where did you attend primary / elementary schooling?

Were there any concerns noted by teachers or parents, or challenges you experienced?

Where did you attend secondary schooling (i.e., middle / high school)?

Were there any concerns noted by teachers or parents, or challenges you experienced?

What is the last grade/level of schooling that you completed?

If you did not complete school, what were your reasons for not completing school?

What were your best subjects in school?

What were your worst subjects in school?

Have you ever been diagnosed with a learning disability? ◯ Yes ◯ No If yes, what areas?

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Occupational Information

Are you currently working? ◯ Yes◯ 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?

What do you see as your weaknesses?

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Please list the results you would like to see from our psychoeducational services.

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.