



Adult Medical / Developmental History Form

This questionnaire should take approximately 30 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, address & fax number 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
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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)

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

- | | |
|-----------------------------------|---------------------|
| <input type="checkbox"/> Drinking | How much? (approx.) |
| <input type="checkbox"/> Smoking | How much? (approx.) |
| <input type="checkbox"/> 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

- | | | |
|---|---|---|
| <input type="checkbox"/> Cord around neck | <input type="checkbox"/> Bruising | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Oxygen deprivation | <input type="checkbox"/> Treatment for jaundice |
| <input type="checkbox"/> Cyanosis | <input type="checkbox"/> Birth injury | |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Required oxygen | |

Other complications?

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

What is known about your behaviour, mood, and temperament for the first 3 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 development (e.g., using words, sentences)

If yes, please explain:

Developmental milestones

<u>Milestones</u>	Significant delay	Somewhat delayed	Normal range	Unknown
First words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Trained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feed self independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Button and unbutton clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress self independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tied own shoelaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Not easily calmed | <input type="checkbox"/> Abnormal weight |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Nightmares/terrors | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Number of accidents | <input type="checkbox"/> Difficult to console | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Tubes (ear infections) | <input type="checkbox"/> Head banging | <input type="checkbox"/> Easily agitated | <input type="checkbox"/> Stuttering |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Restless | <input type="checkbox"/> Unusually active | <input type="checkbox"/> Difficulty speaking |
| <input type="checkbox"/> Poor weight gain | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> Drooling | <input type="checkbox"/> Poisoning / exposure | <input type="checkbox"/> Unresponsive | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Disrupted sleep | <input type="checkbox"/> Into everything | <input type="checkbox"/> Climbing |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Abnormal height | <input type="checkbox"/> Isolated, bullied and/or teased |
| <input type="checkbox"/> Anxiety in social situations | <input type="checkbox"/> Social withdrawal | | |

Other:

Please explain any of these problems:

Are you:

Right-handed

Left-handed

Ambidextrous

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
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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.)

<u>Issue</u>	<u>Maternal side</u>	<u>Paternal side</u>
<input type="checkbox"/> Learning problems		
<input type="checkbox"/> Attention / concentration		
<input type="checkbox"/> Autism		
<input type="checkbox"/> Anxiety		
<input type="checkbox"/> Obsessive compulsive		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Drug/alcohol abuse		
<input type="checkbox"/> Intellectual disability		
<input type="checkbox"/> Schizophrenia		
<input type="checkbox"/> 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?

Hospitalizations?

Current Medications	Dosage	Reason Prescribed	Side Effects
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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? Please indicate the dosage.

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

- | | |
|--|---|
| <input type="checkbox"/> Abuse (physical, emotional, sexual) | <input type="checkbox"/> Alcohol or drug abuse by partner or relative |
| <input type="checkbox"/> Sexual assault | <input type="checkbox"/> Serious illness or disability in someone close |
| <input type="checkbox"/> Death of someone close to you | <input type="checkbox"/> 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
- Pain

Cognitive:

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

Other:

Other:

CONTINUED:

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:

Social:

Social withdrawal

Social isolation

Difficulty understanding jokes/sarcasm Difficulty
expressing emotions/feelings Difficulty holding a
conversation Difficulty with small talk

Trouble with eye contact

Trouble making friends

Trouble maintaining friends

Trouble reading social cues

Trouble with change and transition

Feeling easily overwhelmed by surroundings

Difficulty with anxiety in social situations

Difficulty with showing facial expressions

Other

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.)
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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:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> N/A
At work:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> N/A
With family:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> N/A
With friends:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> N/A
With neighbours:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> N/A

Educational Information

Where did you attend primary / elementary

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?

Where did you attend college/university?

Any other certificates or trainings?

Were there any concerns or challenges you experienced?

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?

Social Information

Do you have any best friends? If no, why not?

Where do you see your friends and what kind of activities do you do together?

Do you share similar interests with your friends? Please explain.

Have you been bullied or teased before? Please explain when and why.

Have you had any difficulties in dating or intimate relationships? Please explain duration of the relationship and the nature of the difficulties.

Please list the results you would like to see from our psychological 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@talkn thrive.com or through OWL Secured

Messaging.