65 Thomas Johnson Drive, Suite A, Frederick, MD 21702

Adult Developmental History Form

Please fill out this questionnaire as completely as possible. All information is confidential and will be protected in accordance with State and Federal law.

Client Name: ____________________ **Date**: ______________________________

Information supplied by (name and relationship to the client): ______________________________

Presenting problem(s):

____

____

____

Client's Information

Client's full legal name: _______________________________Birth date:________________

Address:____

____

Telephone: home ________________ Work ______________ Cell ____________

Preferred nickname: ________________________

Gender: M F Date of Birth: _________________

Marital Status: ____________________________

Ethnic identification: __________________

Primary language: ____________________ Other languages spoken __________

Handedness: ☐ Left or ☐ Right

Alternate Contacts

Emergency Contact Name: ____

Telephone number: ___________________ Relationship: ___________________________

Family and Home Information:

All additional persons currently living in the household:

Name	Birth date	Sex	Education level	Relationship

Developmental History (complete as known)

Has this client had any serious illness? Yes (please specify) No

____

____

Has this client had any head injuries? Yes (please specify) No

____

____

Is this client on medication at this time? Yes (please specify) No

____

____

Please complete as much of the following about the client as possible:

Is this client adopted? Yes No If yes, at what age?________________________________

<u>During pregnancy, did this client's mother :</u>

Have high blood pressure? Yes No Don't Know
Have diabetes or sugar in urine? Yes No Don't Know
Have kidney problems or protein in urine? Yes No Don't Know
Have German Measles? Yes No Don't Know
If yes when? ______________
Drink alcoholic beverages? Yes No Don't Know
About how much?____________
Use any medications? Yes No Don't Know
Have hormone pills or injections? Yes No Don't Know

Take any medications? Yes No Don't Know
If yes, what?______________________
Have recurrent emotional problems? Yes No Don't Know
Bleeding? Yes No Don't Know
If yes, when?_______________________
Frequently smoke cigarettes? Yes No Don't Know
If yes how much? _______________
Have a drug dependency ? Yes No Don't Know
Other list:_____________________________

Prenatal problems? Yes No
If yes, please explain: ____

____

Was delivery: Difficult? Easy? Slow? Quick?
Caesarean section Breech Forceps Suction

Other complications:____

____

____

____

____

____

Milestones

Was the client's development in the following areas early, normal or delayed (list ages if known):

	EARLY	NORMAL	DELAYED
Stand Alone			
Walk by Self			
Spoke first words (other than Mama/Dada)			
Spoke first real sentences			

Any difficulties with above?____

Client's Medical History:

Client's Physician: ________________________________ Phone: ______________________________

Name of Medical Group: _________+____

Hearing Aids ☐ No ☐ Yes

Glasses ☐ No ☐ Yes If glasses, what for _______________________________

Does or did the client have lead poisoning? ☐ No ☐ Yes

If "yes," please explain: ____

Please detail any of the client's hospitalizations:

Date	Age	Hospital	Reason	Length of stay

Please detail any medication history:

Date	Age	Drug	Reason	Physician

Respiratory

Frequent Colds No ___ Yes ___

Chronic Cough No ___ Yes ___

Asthma No ___ Yes ___

Hay Fever No ___ Yes ___

Sinus Condition No ___ Yes ___

Cardiovascular

Shortness of Breath or Dizziness with Physical Exertion No ___ Yes ___

Activity Limitation Due to Heart Condition No ___ Yes ___

Heart Murmur No ___ Yes ___

Gastrointestinal

Excessive Vomiting No ___ Yes ___

Frequent Diarrhea No ___ Yes ___

Constipation No ___ Yes ___

Stomach Pain No ___ Yes ___

Genitourinary

Urination in Pants/ Bed No ___ Yes ___

Pain While Urinating No ___ Yes ___

Musculoskeletal

Muscle Pain No ___ Yes ___

Clumsy Walk No ___ Yes ___

Poor Posture No ___ Yes ___

Skin

Frequent Rashes No ___ Yes ___

Bruises Easily No ___ Yes ___

Sores No ___ Yes ___

Severe Acne No ___ Yes ___

Itchy Skin (Eczema) No ___ Yes ___

Neurological

Seizures/ Convulsions No ___ Yes ___

Speech Defects No ___ Yes ___

Accident Prone No ___ Yes ___

Grinds Teeth No ___ Yes ___

Has tics/twitches No ___ Yes ___

Bangs Head No ___ Yes ___

Rocks Back and Forth No ___ Yes ___

Allergies

Allergy to Medicine No ___ Yes ___

Allergy to food No ___ Yes ___

Other allergies No ___ Yes ___

Speech

Stuttering No ___ Yes ___

Unclear Speech No ___ Yes ___

Other speech problems No ___ Yes ___

Hearing

Severe Ear Infections No ___ Yes ___

Hearing Problems No ___ Yes ___

Ear Tubes No ___ Yes ___
(If yes, number of times:__________)

Family Medical History

Is there a history of any of the following in the family?
(Use "M" for mother's side; "F" for father's side.)

____________	TB	____________	Vision problems
____________	Birth defects	____________	Hearing problems
____________	Emotional problems	____________	Drugs
____________	Behavior problems	____________	Alcohol
____________	Mental retardation	____________	Diabetes
____________	Goiter (Thyroid)	____________	Convulsions/seizures
____________	Other	____________	Other

Further comments: ____

____

____

____

Treatment History

Please include (chronologically if possible) as complete a history as possible. Include agencies, physicians, counselors, institutions, therapists, etc.

Date	Age	Contact person	Services provided	Length of involvement

Has the client been court involved? ☐ No ☐ Yes

If "yes," please explain: ____

____

Client's School History

	Year	Location	Problems (Y/N)	Details/Degree
Preschool				
Kindergarten				
Elementary				
Middle School				
High School				
College				

Did the client experienced any of the following in school?

Learning Problems   Discipline Problems   Social Problems   Emotional Problems
Attention Problems

If you answered "yes," to problems at any academic level, please detail here. Please give any information about treatment (if any) provided by the school at the time of occurrence:

____
____
____
____

Previous Testing

Has there been any academic or psychological testing done at school or elsewhere?   Yes   No

If yes, what type of testing?____________________When:______________________________

Results: ____

Client's Work History:

Dates	Position/Job Duties	Employer	Reason for Leaving

Please circle the number which best describes the client on each particular problem.

	NOT A PROBLEM	SOMEWHAT A PROBLEM	A PROBLEM	A SEVERE PROBLEM
PROBLEMS WITH SLEEPING				
Trouble Sleeping	1	2	3	4
Nightmares	1	2	3	4
Sleep walking	1	2	3	4
Sleep talking	1	2	3	4
SCHOOL PROBLEMS (if applicable)				
Has problems learning in school	1	2	3	4
Has conflicts with teachers	1	2	3	4
Performs below his/her ability	1	2	3	4
BEHAVIOR PROBLEMS				
Uses alcohol	1	2	3	4
Uses drugs	1	2	3	4
Other:	1	2	3	4
COMMUNICATION SKILLS				
Limited Speech	1	2	3	4
Repetitive Speech	1	2	3	4
Regression in Speech	1	2	3	4
SOCIAL SKILLS				
Social Anxiety	1	2	3	4
Withdraws from people	1	2	3	4
EMOTIONAL PROBLEMS				
Has unreasonable fears				
Is sad or unhappy most times	1	2	3	4
Cries a lot	1	2	3	4
Sluggish or Slow	1	2	3	4
Tired most of the time	1	2	3	4
Mood changes quickly	1	2	3	4
Has lost interest in things	1	2	3	4
Worries a great deal	1	2	3	4
Has difficulty making decisions	1	2	3	4
Wants things to be perfect	1	2	3	4
ATTENTION AND SELF-CONTROL				
Has difficulty concentrating	1	2	3	4
Is easily distracted	1	2	3	4
Can't sit still	1	2	3	4
Hyperactive	1	2	3	4
Acts without thinking	1	2	3	4
Acts impulsively	1	2	3	4
Is disorganized	1	2	3	4
OTHER				

Please describe other problems: ____

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____

____

What concerns are most distressing? ____

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____

What do you think are the client's greatest strengths? ____

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Please describe the changes you hope to see in the client as a result of our work:

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Completed by: ____

Signature: ____ **Date: ______________**