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Developmental History - Young Adult

Patient Name: _____
First Middle Last

Date of Birth: _____

Today's Date: _____

Please describe your main concerns: _____

_____

_____

Family Information

Parents are: ❑Married ❑Separated ❑Divorced ❑Not married but live together ❑Not married and do not live together

Please list any step-parents or other adults involved significantly in your life: _____

_____

Please list siblings and ages: _____

_____

Please share any history of learning issues, depression/anxiety, ADHD or other mental health diagnoses in your immediate and extended family: _____

_____

Please describe any significant stressors that may be affecting you: _____

_____

_____

Social Development

Briefly describe your personality:_____

_____

Please list your extracurricular activities: _____

_____

_____

Do you have any concerns about your friendships and ability to make and keep friends?

_____

_____

Do you have any concerns about your mood, focus or self-control? _____

_____

_____

Developmental History

As a young child, did you have any delays in: ❑Motor development ❑Language development ❑Behavioral control or toilet training If yes, please explain: _____

_____

Did you receive any early intervention services such as speech therapy or OT? If yes, please explain:_____

_____

Medical History

Primary Care Physician:_____

Please describe any current or past: Medical problems? Vision problems? Hearing problems?

_____

Please describe any past hospitalizations: _____

_____

Are you under the under the care of any other health professionals? ❑Yes ❑No

If yes, with whom? _____

Do you have a current acute or chronic medical illness? ❑Yes ❑No

Diagnosis: _____

Have you ever been given a psychological diagnosis? ❑Yes ❑No:

Diagnosis: _____

Have you participated in therapy or counseling services in the past?

❑Yes ❑No If yes, with whom?_____

Do you have a history of concussion? ❑Yes ❑No

If yes, when and how long before symptoms resolved? _____

_____

Please list any medications you are currently taking: _____

_____

Do you currently smoke or drink alcohol? ❑Yes ❑No Do you consider this to be a problem?

If yes, please explain:_____

_____

Academic History

Current School: _____ Grade Level:_____

Other schools attended, beginning with preschool: _____

Did you skip a grade? ❑Yes ❑No Were you ever retained? ❑Yes ❑No

Did you ever receive tutoring services or were you evaluated/testing for learning problems?

If yes, to any of the above, please describe: _____

_____

_____

Are you currently having any academic difficulty? ❑Yes ❑No

If yes, please describe: _____

_____

Are you experiencing disciplinary problems in school or on the job? ❑Yes ❑No

Have you ever been suspended? ❑Yes ❑No Or expelled? ❑Yes ❑No

If yes to any of the above, please describe: _____

_____

Did you ever have a 504 Plan, an IEP or a formal written learning plan on file at school?

Please describe the services you received: _____

_____

Is there any other information not covered on this form that you feel would be helpful or relevant? _____

_____

_____

_____

Thank you!