Adult Neurodevelopmental History Form

First Name ______ Last Name ______

Sex ______ Birth Date ______ Current Age ______

Place of Birth ______ Where did you grow up? ______

Years of Education ______ Highest Degree Achieved ______ School/ District ______

Home Address ______ City ______ State ______ Zip ______

(_____)_____-________ Home Phone (_____)_____-_________ Cell Phone (_____)_____-________ Work Phone

Current Medications (***Including dosage and frequency***)

______

______

______

Who are you currently living with? [full names and ages] ______

______

Who referred you? ______
Address ______ Phone # ______

Reason for referral:

______

______

______

Is an attorney involved in this case? ☐ Yes ☐ No Name ______ Phone ______
If your attorney has not requested an independent examination, we will only be responding to the referral questions of your referring clinician. We might not address specific medico-legal questions your attorney may have. If you have any questions about this issue, you should contact your attorney.

Do you want a copy of your report sent to your attorney? ☐ Yes ☐ No

Is there a guardian for the patient? ☐ Yes ☐ No a conservator? ☐ Yes ☐ No

	Name of School	Year graduated	Degree	Major
High school				
2 yr College				
University				
Post-graduate study				
Post-graduate study				

I. Pregnancy and Delivery (of mother; when pregnant with you)

Duration of pregnancy (weeks) ______ (full term = 40 weeks)

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

☐ Excessive vomiting
☐ Threatened miscarriage
☐ Spotting/ bleeding
☐ Infections
☐ Toxic exposure
☐ Trauma (*physical/mental*)
☐ RH incompatibility
☐ Diabetes
☐ Toxemia
☐ High blood pressure (*hyper tension*)
☐Anemia
☐ Physical Injury
☐Drinking (*How much?*______)
☐ Smoking (*How much?*______)
☐ Drug abuse (*which drugs?*______)

Surgeries during pregnancy? Yes ☐ No ☐
Specify: ____________________

Other illness during pregnancy: ____________________
Medications taken during: ____________________

Other significant events, complications or diagnostic procedures? (*Please explain*)____________________
____

Delivery
Labor: Spontaneous ☐ Induced ☐ Duration (*hours*) ________

Delivery: Vaginal ☐ Breech ☐ C-Section ☐
Apgar scores (*if known*) ☐
Birth weight: Lbs _______ Oz _______

Complications: ☐ Cord around neck ☐ Hemorrhage ☐ Cyanosis ☐ Forceps ☐ Bruising
☐ Oxygen deprivation ☐ Birth injury ☐ Required oxygen ☐ Transfusions
☐ Treatment required for jaundice
☐ Infection (*please explain*) ____________________
☐ Other complications? ____________________
Specialized care (incubator, oxygen, etc.)? ____________________

Did you have:
☐ Problems sucking ☐ Problems growing ☐ Excessive sleep
☐ Problems swallowing ☐ Unusual stiffness ☐ Milk allergies
☐ Feeding problems ☐ Problems sleeping ☐ Other allergies
☐ Other ____________________

What is known about your behavior, mood, and temperament for the first **18-25** months?
____

II. Developmental progression

Developmental milestones (*age achieved*) Please be as precise as possible.

1. _____ Rolled over? 2. _____ Sat up? 3. _____ First words? 4. _____ Sentences?
5. _____ Bladder trained (day)? 6. _____ Bladder trained (night)? 7. _____ Bowel trained?
8. _____ Walked?

Were any of the following present to an **unusual** degree during the **first six years** of life?
Please check those that apply and explain as necessary:

☐ Allergies
☐ Ear infections
☐ Tubes (i.e. for ear infections)
☐ Eating problems
☐ Drooling
☐ High fevers
☐ Head aches
☐ Poisoning/Toxic exposure
☐ Poor weight gain
☐ Lethargic
☐ Colic
☐ Head-banging
☐ Clumsy, un-coordinated
☐ Unusual number of accidents

☐ Restless
☐ Disrupted sleep
☐ Not easily calmed
☐ Difficult to console
☐ Masturbation
☐ Irritability
☐ Unresponsive
☐ Aggressive
☐ Thumb-sucking
☐ Nightmares
☐ Easily agitated
☐ Unusually active
☐ Into everything/Climbing
☐ Other________________________________

Are you : ☐ Right-handed ☐ Left-handed ☐ Ambidextrous?
When did handedness become evident?
____

Did you ever change handedness? Yes ☐ No ☐ Family history of left handedness? Yes ☐ No ☐

Did you enjoy drawing/coloring as a toddler/preschooler? Yes ☐ No ☐
Explain: ____
____

At what point did you become concerned about your development and/or behavior?
____
____

Have any of your siblings experienced problems of development or mastery of skills? Yes ☐ No ☐
Explain: ____
____

III. Family History

Biological Mother: ____________________________ Age: ____________ Education: ______________
Highest grade completed? ____ (1-12) High School Graduate/ GED (circle)
Number of college credit hours completed? ____ Degree? ____________
Vocational training? ______________________ Years? ____________
Current occupation? ______________________ Hours per week? _____
Business name? ____
Learning problems? ____
Behavioral problems/ psychiatric disorder? ____
Medical problems? ____
Have any of your maternal blood relatives experienced problems similar to those you are currently experiencing? *If so, please describe*____
____

Biological Father: ____________________________ Age: ____________ Education: ______________
Highest grade completed? ____ (1-12) High School Graduate/ GED (circle)
Number of college credit hours completed? ____ Degree? ____________
Vocational training? ______________________ Years? ____________
Current occupation? ______________________ Hours per week? _____
Business name? ____
Learning problems? ____
Behavioral problems/ psychiatric disorder? ____

Medical problems? ____
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

Name______________________Age______Medical/Social/School problems

____
____
____
____
____

Check all that apply:

Maternal:

- ☐ Learning problems
- ☐ School problems
- ☐ Attention/Concentration problems
- ☐ Hyperactivity
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Unreasonable fears (phobias)
- ☐ Depression
- ☐ Suicide
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Psychiatric hospitalization
- ☐ Other _______________________

Paternal:

- ☐ Learning problems
- ☐ School problems
- ☐ Attention/Concentration
- ☐ Hyperactivity
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Unreasonable fears (phobias)
- ☐ Depression
- ☐ Suicide
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Psychiatric hospitalization
- ☐ Other _______________________

IV. School Experiences/ Learning problems

Rate your school experiences relative to academic learning.

Good____________________Average____________________Poor

Preschool____
Kindergarten____
Grade School____
Junior High ____
High School ____
College ____

Rate your school experiences relative to behavior.

Good____________________Average____________________Poor

Preschool____
Kindergarten____
Grade School____
Junior High ____
High School ____
College ____

Were you ever retained for any reason or has retention ever been suggested? Yes ☐ No ☐
If yes, please explain ____

Have you ever been in resource or special education placement? Yes ☐ No ☐
If yes, please explain ____

Have you ever been referred for special education? Yes ☐ No ☐
If yes, please explain ____

V. Work History

Are you employed outside the home? Yes ☐ No ☐
If yes, what is your occupation? ___________________How many hours per week do you work? ________
If no, are you unable to work because of an injury or illness? Yes ☐ No ☐
Last date worked: _____________ If not working now, what was your former occupation?_______________

VI. Military History

____
____
____
____

VII. Present Medical Status

Hair Color: ____________ Eye Color: ____________

Height ___’____” Weight _______lbs.

Medications currently prescribed (*include dosage/frequency*):
____
____
____

Other medications you have taken for an extended period of time:
____

Have you ever had (a) seizure (s)? ____ with fever? ____ without?

Have you ever experienced loss of consciousness? Yes ☐ No ☐
Explain:____

Surgeries? ____
Hospitalization (s)? ____
Temperature over 104 degrees? ____

Please check if you have had any of the following illnesses or conditions:

☐ AIDS/HIV positive
☐ Arthritis
☐ Asthma/Bronchitis
☐ Broken bones/fractures
☐ Cancer
☐ Chronic Fatigue Syndrome
☐ Concussion/Head Injury
☐ Diabetes
☐ Epilepsy/Seizures
☐ Liver Disease
☐ Exposure to toxins (such as lead, mercury, solvents)
☐ Fibromyalgia
☐ GERD
☐ Heart Disease
☐ High Blood Pressure
☐ Hypoglycemia
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Lung Disease
☐ Lupus
☐ Meningitis
☐ Migraines
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Polio
☐ Stroke
☐ Thyroid Disease
☐ Tumor
☐ Ulcer

Which of the following problems have you experienced?

☐ Drug/substance abuse
☐ Violent behavior
☐ Trouble with the law
☐ Suicidal threats
☐ Depression
☐ Sexual abuse (*victim*)
☐ Alcohol abuse
☐ Sexually active
☐ Sexual abuse (*perpetrator*)

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

Behavioral:
☐ Hyperactivity
☐ Impulsivity
☐ Low frustration tolerance
☐ Interrupting frequently
☐ Sudden acts of aggression
☐ Heedless to danger
☐ Acting as if 'driven by a motor'
☐ Temper outbursts
☐ A 'different person'
☐ Disorganized
☐ Accident prone
☐ Nail-biting
☐ Excessive Swearing
☐ Sloppiness
☐ Anxiety
☐ Aggression
☐ Depression
☐ Social Withdrawal

Cognitive:
☐ Tics/twitching
☐ Sleep-walking
☐ Clumsiness
☐ Avoidance of Reading
☐ Not listening
☐ Poor memory
☐ Not thinking logically
☐ Problems understanding jokes
☐ Problems finding the 'right' word
☐ Poor awareness of time
☐ Poor attention span
☐ Problems expressing thoughts or ideas
☐ Difficulty finishing tasks
☐ Difficulty listening
☐ Problem expressing emotion
☐ Not learning from mistakes/experience
☐ Getting lost easily
☐ Ask for repetitions often

VIII. Neurological History

<u>Complete this section **only** if you have seen a neurologist or neurosurgeon for some diagnosed disease or injury (e.g., brain tumor, seizures, infectious diseases of the brain, head injury).</u>

<u>*Check all that apply to you.*</u>

☐ Birth injury
☐ Spinal cord injury
☐ Developmental disorder

☐ Brain tumor
☐ Meningitis
☐ Head injury/concussion
☐ Other (*specify*) ______________________
☐ Endocrine problems
☐ Cerebral Palsy
☐ Traumatic brain injury
☐ Seizures
☐ Encephalitis
☐ Headaches

Age at initial diagnosis ______

Presenting complaints or symptoms:
____
____
____

Diagnosis ______________________________________
Current neurologists/ neurosurgeons:
____
____

Previous neurologists/neurosurgeons that have seen you:
____
____

Have you had or are you having seizures currently? __________________
Date of last seizure? _______________________

Diagnostic procedures completed:
☐ CT Scan *date (s)* ____________
☐ MRI Scan *date (s)* ____________
☐ SPECT Scan *date (s)* ____________
☐ PET Scan *date (s)* ____________
☐ Spinal Tap *date (s)* ____________
☐ EEG *date (s)* ____________

Hospitalizations: (*include date and reason*)
____
____

Neuropsychological procedures? Yes ☐ No ☐
*If yes, please explain:*________________________________
____
Have you ever received any psychological or psychiatric treatment? Yes ☐ No ☐
*If yes, by whom and when?*______________________________
____
Psychological testing completed? *When and by whom?*______________________
____

Please list all of the doctors, therapists, and other providers treating you right now.

Name	Specialty	Phone Numbers

Family physician: ____________________

Have you experienced any of the following?

Formal diagnosis of emotional psychiatric problems? Yes ☐ No ☐
Treatment by a psychiatrist, psychologist, or psychotherapist? Yes ☐ No ☐
Hospitalization for emotional or psychiatric problems? Yes ☐ No ☐
Taken medication for emotional or psychiatric problems? Yes ☐ No ☐

Have you noticed any problems in your sense of:

- ☐ vision
- ☐ hearing
- ☐ smell
- ☐ taste
- ☐ touch

Are you having any problems with:

- ☐ alertness
- ☐ anger
- ☐ appetite
- ☐ balancing checkbook
- ☐ concentration
- ☐ coordination
- ☐ dizziness
- ☐ driving
- ☐ energy
- ☐ fainting
- ☐ headaches

Are you having any problems with:

- ☐ irritability
- ☐ memory
- ☐ numbness
- ☐ pain
- ☐ reading
- ☐ sadness
- ☐ sense of direction
- ☐ sleep
- ☐ speech
- ☐ balance in walking
- ☐ weakness
- ☐ writing

Do you smoke? Yes ☐ No ☐ *If so, how much?*____________________
Have you quit smoking? Yes ☐ No ☐ *If yes, when did you stop?* ____________________
How much alcohol do you drink?____________________
Have you ever been arrested for DUI/DWI? Yes ☐ No ☐ *If yes, when?*____________________
Have you ever been treated for problems related to alcohol use? Yes ☐ No ☐ *If yes, when?*__________
Have you ever used street drugs (including marijuana) regularly? Yes ☐ No ☐ *If yes, which ones?*
____

Please rate the amount of stress you are currently experiencing

	Little or none						Extreme	
At home:	1	2	3	4	5	6	7	NA
At work:	1	2	3	4	5	6	7	NA
With extended family:	1	2	3	4	5	6	7	NA
With friends:	1	2	3	4	5	6	7	NA
With neighbors:	1	2	3	4	5	6	7	NA

In addition to this history form, the additional information that was requested during the initial telephone conversation would also be helpful. This includes your child's birth and medical records if relevant and preschool and/or school records, including evaluation reports by school personnel. If your child has had any evaluations outside of the school, we would appreciate copies of these, as well.

X. Additional Remarks

Please write any additional remarks you may wish regarding your problems.