DEVELOPMENTAL HISTORY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. As far as you know, were there any problems with your mother’s Yes No

Pregnancy with you? If yes, please give details:

1. Were there any problems associated with her delivery or you? Yes No

If yes, please give details:

1. Did you mother use alcohol or other drugs during the pregnancy? Yes No

If yes, please give details:

1. Did your mother smoke cigarettes during the pregnancy? Yes No

If yes, please give details:

1. Did you have any significant delays in your development Yes No

(i.e. in walking, talking, or sitting up)?

If yes, please give details:

1. Did you have any serious childhood illnesses/diseases/major surgeries? Yes No

If yes, please give details:

1. Did you have any problems getting along with other children when Yes No

you were a child? If yes, please give details:

1. Please place a checkmark beside any of the following that you believe you had significant difficulties with as a child:

\_\_\_\_ Defiant \_\_\_\_ Aggressive \_\_\_\_ Stubborn \_\_\_\_ Destructive

\_\_\_\_ Hyperactive \_\_\_\_ Impulsive \_\_\_\_ Inattentive \_\_\_\_ Distractible

\_\_\_\_ Shy \_\_\_\_ Withdrawn \_\_\_\_ Depressed \_\_\_\_ Anxious

\_\_\_\_ Fearful \_\_\_\_ Lying \_\_\_\_ Stealing \_\_\_\_ Fighting

\_\_\_\_ Learning \_\_\_\_ Language \_\_\_\_ Memory \_\_\_\_ Motor skills

\_\_\_\_ Sleeping \_\_\_\_ Eating \_\_\_\_ Toilet Training

\_\_\_\_ Strange ideas (explain):

\_\_\_\_ Strange behavior (explain):

EMPLOYMENT HISTORY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your current employment status (circle one)?
2. Full Time c. Unemployed e. Homemaker
3. Part Time d. Student f. Disabled
4. If employed, what is your current occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. If employed, what is your current employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. If employed, how long have you worked in your present job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Please give us your history of previous employment since completing your education:

Job title Time on job (years) Reason for leaving

1. What is your longest period of employment at one place? \_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever been fired from a job? Yes No
If yes, how many jobs were you fired from or asked to leave by your employer? \_\_\_\_\_\_\_\_\_
3. Have you ever served in the military? Yes No
If yes, please give details:
4. Briefly describe the types of problems you have experienced with work, either at your current job, or in the past:

HEALTH HISTORY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had any of the following:

Type of problem During childhood As an adult Currently

Allergies / asthma .

Heart problems .

Epilepsy or seizures .

High blood pressure .

Serious head injury .

Injury resulting in
loss of consciousness .

Lead poisoning .

Broken bones .

Surgery .

Migraine headaches .

Thyroid condition .

Problems with vision .

Problems with hearing .

Diabetes .

Any other serious medical problems (explain): .

 .

Are you currently taking any medications? Yes No

If yes, please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

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Please describe any other health difficulties you have experienced now or in the past:

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SOCIAL HISTORY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How would you describe your mood most of the time? (circle one)
2. Cheerful/happy c. Sad/depressed e. Changes all the time
3. Anxious/nervous d. Angry/irritable f. Bland/unfeeling
4. Do your moods change very frequently, abruptly, and/or unpredictably? Yes No
If yes, please give details:
5. Do you have trouble making friends? Yes No
6. Do you have trouble keeping friends? Yes No
7. Do you have trouble in your relationships with others? Yes No
If yes, please give details:
8. Do you have problems with your temper? Yes No
9. Do you have a driver’s license? Yes No
10. Has your license ever been suspended? Yes No
If yes, please give details:
11. How many speeding tickets have you ever gotten? \_\_\_\_\_\_\_\_\_\_\_\_
12. Have you ever been stopped for driving while intoxicated? Yes No
13. How many car accidents, regardless of fault, have you ever been involved in? \_\_\_\_\_\_\_\_\_\_\_
14. How many times did your family move during your childhood and adolescent years? \_\_\_\_\_\_\_\_\_
15. How many times have you moved since leaving high school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
16. If you believe that you have attention deficit hyperactivity disorder, or ADHD, please tell us in what way have your ADHD symptoms interfered with your life?
17. In what ways have you tried to compensate for or cope with your deficits?