

DEVELOPMENTAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis. Please complete these forms as best you can. We will have the opportunity to discuss them in detail at your appointment.

TODAY'S DATE: _____

NAME	DATE OF BIRTH	AGE
WORK PHONE	HOME PHONE	
ADDRESS		
SPOUSE'S NAME	WORK PHONE	CELL PHONE

Referred by: _____ Phone _____

Address _____

Primary Care Physician _____ Phone _____

Address _____

Have you notified your physician of this appointment: _____

Have you been seen by any of the professionals listed below for emotional/behavioral problems such as depression, anxiety, etc? Please check and list all that apply:

- Psychiatrist _____
- Primary Care Physician _____
- Therapist _____
- Psychologist _____

Please specify the type of treatment received: _____

Why are you seeking professional help at this time:

Outpatient Treatment: _____
 Physician/therapist _____ Address _____ Duration of treatment from _____ to _____

Inpatient Treatment: _____
 Facility Name _____ Address _____ Treating MD _____ Duration of hospitalization _____

Medications used that helped: _____

EDUCATIONAL PLACEMENT:

Did you experience any problems in school? _____ No _____ Yes If yes, please describe:

Have you repeated any grades? _____ No _____ Yes If yes, please describe:

Ever in any type of special education class? _____ No _____ Yes If yes, please describe:

Any behavior problems? _____ No _____ Yes If yes, please describe:

SOCIAL HISTORY:

Married: _____ No _____ Yes Divorced: _____ No _____ Yes # of marriages _____

Children: _____ No _____ Yes Ages _____ # living with you _____

Do you smoke cigarettes? _____ No _____ Yes

Do you currently use any type of drugs? _____ No _____ Yes If yes, what types of drugs and how much per day? _____

Do you currently drink alcohol? _____ No _____ Yes If yes, what type of alcohol and how much per day? _____

Any history of legal problems? Please Specify

List any stressful or traumatic events in your life which may have affected your development and ability to function (i.e., birth of sibling, death in the family, divorce, illnesses, frequent school changes, witnessing a trauma).

<u>Incident</u>	<u>age</u>	<u>comments</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY:

Check all those that apply. In the extra space provided, please describe the condition, and specify the type of treatment received.

- Asthma _____
- Anemia _____
- Seizures _____
- Heart Problems _____
- Thyroid Problems _____
- Glaucoma _____
- High Blood Pressure _____
- Strokes/Heart Attacks _____

List any other existing or recent medical conditions treated

List Surgeries:	Age	Complications
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List other Hospitalizations	Age	Reason	Length of Stay
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List any head injuries	Age	Loss of consciousness
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List any allergies to medications _____

PRESENT MEDICAL STATUS

Current health: ____ poor ____ fair ____ good ____ excellent

Are you in any way physically ill at this time? ____ No ____ Yes, If yes, please explain.

List current medications you are taking. Include dosage and reason. Include vitamin, herbs and over the counter.

Please use this space and any additional sheets for any additional information/comments you wish to share with us about you.

FAMILY PSYCHIATRIC AND MEDICAL HISTORY

Specify which family members suffer from mental health problems or listed medical problems.

Relationship to patient	Medications (specify)	Hospitalizations
Depression		
Bipolar Disorder		
Anxiety Disorder		
Schizophrenia		
Eating Disorder Anorexia/Bulimia		
Learning Disorder		
Substance Abuse Alcohol/Drugs		
ADHD		
Suicide attempt or Completion		
OCD/Obsessive Compulsive Disorder		
Legal Problems		
Violent Behavior		
Speech Problems		
Tourettes/tic Disorder		
Obesity		
Heart Problems		
High Cholesterol		
Epilepsy/Seizures		
Thyroid Problems		
Other: specify type		