Carmel Neuropsychology Services, P.C.

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DEVELOPMENTAL HISTORY

Please fill out this form to the best of your knowledge. If some questions are not applicable to you, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Form completed by: _____ Relationship to patient (if applicable)_____

Date form completed: _____

General Information

Patient's Name: _____ Gender: ☐ Male ☐ Female ☐ Non-Binary
First Middle Last

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Patient's Address: _____
Number and Street City State Zip

Home phone: _____ Cell phone: _____ Work phone: _____

Occupation: _____ Last Grade Completed and Degree (if appropriate): _____

Ethnic/Cultural Background (optional) _____

Primary language spoken in the home: _____ Other language spoken in the home: _____

Marital Status: ☐ Never Married ☐ Married ☐ Unmarried but living in a committed relationship ☐ Widowed ☐ Separated ☐ Divorced

Any previous marriages: ☐ Yes ☐ No If yes, how many times: _____

Number and ages of children: _____

Are they living with the patient? ☐ Yes ☐ No How many? _____

Patient lives: ☐ Alone with no assistance ☐ With spouse or partner/family ☐ Alone with assistance ☐ Senior living environment ☐ Assisted Living ☐ Nursing Home ☐ Other: _____

If patient has assistance at home, please describe:

_____

_____

Emergency Contact Name: _____

Address (if different from patient) _____

Work Phone: _____ Home Phone: _____

Referral Information

Who referred you to us/How did you hear about us?

_____

Address of referral source:_____

Phone number of referral source: _____ Fax number of referral source: _____

If you **DO NOT want us to send a copy of our report to the referral source, please mark here ☐

Current Concerns

Please describe the reason you/the patient was referred to our office:

How long have you/the patient had these problems?

What are you hoping to achieve at the completion of this evaluation?

After reading the patient contract, reviewing the website, and reading what to expect, what questions would you like answered about the procedures the patient will be experiencing at our office?

Are you/the patient under any time constraints regarding any procedures, and if so, please describe:

Will any procedures that will be conducted at our offices be part of an ongoing or expected legal case, and if so, please describe (including the name of attorney or firm, court system, or any other relevant information):

Services/Interventions Sought Previously for this Problem

☐ Medical Evaluation	☐ Neuropsychological Assessment	☐ Educational Testing	☐ Psychiatric Exam
☐ Medication	☐ Neurological Exam	☐ Speech/Language Therapy	☐ Special Education
☐ School Modifications	☐ Psychological Counseling or Therapy	☐ Occupational/Physical Therapy	☐ Tutoring

Has the patient had any of the following forms of psychological treatment? If so, how long did it last?

Individual psychotherapy	☐ Yes	☐ No	Duration and date of therapy? _____
Group psychotherapy	☐ Yes	☐ No	Duration and date of therapy? _____
Residential treatment	☐ Yes	☐ No	Duration and date of placement? _____

Are you/the patient currently receiving psychological treatment? If so, with whom and how often?

What else has been tried to do to help you/the patient with these problems, and how effective were these interventions?

Family History

Birth / Adoptive / Foster Mother's Name: _____ Age _____ Education (Yrs) _____
Occupation: _____

Birth / Adoptive / Foster Father's Name: _____ Age _____ Education (Yrs) _____
Occupation: _____

Have there been any major changes within the family life or the patient's living situation that have affected the patient's functioning (e.g., deaths, moves, divorces, loss of job, etc)? ☐ No ☐ Yes (describe below)

Event	Date

Medical/Health History

What was the date the patient's last physical exam? _____

Patient's primary physician_____ Phone number _____

Vision problem? ☐Yes ☐No Date of last vision exam: _____

Hearing problem? ☐Yes ☐No Date of last hearing exam: _____

Appetite concerns? ☐Normal ☐Abnormal ☐Weight loss/ gain

☐Difficulty swallowing ☐Drooling ☐Gagging

Does the patient have problems falling asleep? ☐Yes ☐No
If a yes, how long does it take for him/her to fall asleep? _____ hours

Does the patient wake up in the middle of the night? ☐Yes ☐No
If Yes, how many times per night typically? _____
How long does it take for him/her to go back to sleep? _____
How many hours total sleep does the patient currently sleep at night? _____

Are there any current concerns related to toileting accidents? ☐Yes ☐No

If yes, please describe: _____

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

Medical History:

Medical Problem	Date of Diagnosis	Description of problem. Please write on the back of this form if necessary

Surgeries: Age: _____ Reason: _____ Where: _____
Other details _____

Surgeries: Age: _____ Reason: _____ Where: _____
Other details _____

Surgeries: Age: _____ Reason: _____ Where: _____
Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____
Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____
Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____

Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____
Other details _____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____
Other details _____

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Other details _____

Has the patient ever been unconscious? ☐ Yes ☐ No If yes, please explain: _____

Has the patient ever been exposed to any toxic chemicals? ☐ Yes ☐ No If yes, please explain: _____

Has the patient had any of the following tests or evaluations?

	Yes	Date (month/ year)	Where	Results
Neurological Evaluation				☐Normal ☐Abnormal ☐Don't Know
CT scan of head				☐Normal ☐Abnormal ☐Don't Know
MRI scan of head				☐Normal ☐Abnormal ☐Don't Know
EEG				☐Normal ☐Abnormal ☐Don't Know
Audiology or hearing evaluation				☐Normal ☐Abnormal ☐Don't Know
Vision evaluation				☐Normal ☐Abnormal ☐Don't Know
Genetic Testing				☐Normal ☐Abnormal ☐Don't Know
Other laboratory tests				☐Normal ☐Abnormal ☐Don't Know

Family Medical History

Mother: Health, learning, mental health problems, drug or alcohol problems? (please specify) _____

Father: Health, learning, mental health problems, drug or alcohol problems? (please specify) _____

Patient's siblings: Health, learning, mental health problems, drug or alcohol problems? (please specify)_____

Have any of the patient's family members had the following problems/disorders? Please specify the family member's relationship to the patient and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

	Family Member(s) Relation to Patient		Family Member(s) Relation to Patient
☐ Academic Problems	_____	☐ Alcohol/ Drug abuse	_____
☐ Anxiety	_____	☐ Attention Deficit Disorder	_____
☐ Autism/ Asperger's	_____	☐ Bipolar disorder	_____
☐ Birth defect	_____	☐ Cancer	_____
☐ Cerebral palsy	_____	☐ Dementia	_____
☐ Depression	_____	☐ Diabetes	_____
☐ Genetic disorder	_____	☐ Heart Disease	_____
☐ Huntington's chorea	_____	☐ Mental retardation	_____
☐ Migraine headaches	_____	☐ Multiple sclerosis	_____
☐ Muscular dystrophy	_____	☐ Obsessive-Compulsive Disorder	_____
☐ Oppositional/ defiant behaviors	_____	☐ Parkinson's Disease	_____
☐ Physical handicap	_____	☐ Physical/ sexual abuse	_____
☐ Schizophrenia	_____	☐ Seizures or epilepsy	_____
☐ Sickle-cell anemia	_____	☐ Speech/ language delay	_____
☐ Stroke	_____	☐ Tics/ Tourette's Disorder	_____
☐ Traumatic Brain Injury	_____		

☐ Other (specify): _____

_____

Personal/Social Information

What are the patient's main hobbies and interests?

How often is the patient participating in these activities?

Are there any activities/hobbies the patient has stopped, and if so, why?

Educational History

What was the highest grade completed? ☐ Less than High School (_____ Grade) ☐ GED (Last Grade Completed ____)

☐ High School ☐ Associate's Degree ☐ Bachelor's Degree ☐ Graduate Degree (Specify: _____)

Were there any identified learning disabilities during school years? ☐ Yes ☐ No
If yes, please describe: _____

Was the patient in special education? ☐ Yes ☐ No
If yes, for what reason? _____

Any concern about possible difficulties that were not identified? ☐ Yes ☐ No
If yes, please describe:
_____

Was the patient ever retained in school? ☐ Yes ☐ No What grade? _____Why?_____

Occupational History

Present or Most Recent Job (Include job titles, description of work, years employed): _____

_____

Previous Jobs (job titles, description of work, years employed, and reason for change):
_____

_____

_____

_____

Any problems encountered in your work activities? _____

_____

_____

Are you currently involved in a Worker's Compensation case? ☐ Yes ☐ No

Any previous Worker's Compensation history? ☐ Yes ☐ No

If yes to either question, provide details: _____

_____

_____

Is the patient currently receiving disability? ☐ Yes ☐ No If yes, specify condition: _____

Is the patient currently applying for disability? ☐ Yes ☐ No If yes, specify condition: _____

Emotional Functioning

The Patient:	Not at all	Just a little	Pretty much	Very much	Not applicable
Has decreased interest or pleasure in daily activities	☐	☐	☐	☐	☐
Has significant weight loss or gain, poor appetite or over-eating without deciding to diet or trying to gain.	☐	☐	☐	☐	☐
Has difficulty sleeping or is sleeping too much	☐	☐	☐	☐	☐
Has low energy or fatigue	☐	☐	☐	☐	☐
Seems excessively agitated ☐ or slowed down ☐ (check if positive)	☐	☐	☐	☐	☐
Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	☐	☐	☐	☐	☐
Has or difficulty making decisions	☐	☐	☐	☐	☐
Has feelings of hopelessness	☐	☐	☐	☐	☐
Has recurrent thoughts of death	☐	☐	☐	☐	☐
Has talked about or attempted suicide	☐	☐	☐	☐	☐
Has a persistent refusal to go to school in order to stay home with a parent	☐	☐	☐	☐	☐
Has excessive anxiety or worry	☐	☐	☐	☐	☐
Feels that worry is difficult to control	☐	☐	☐	☐	☐
Is restless or feels keyed up or "on edge"	☐	☐	☐	☐	☐
Is easily fatigued	☐	☐	☐	☐	☐
Has irritability	☐	☐	☐	☐	☐
Has muscle tension	☐	☐	☐	☐	☐
Has difficulty falling or staying asleep, or restless unsatisfying sleep	☐	☐	☐	☐	☐
Have repetitive behaviors, such as hand-washing, lining things up, checking on things before leaving a room or leaving the house, or mental acts such as a need to keep counting things or repeating words over and over.	☐	☐	☐	☐	☐
Has thoughts that persist and keep coming back, that cause worry or anxiety	☐	☐	☐	☐	☐
Has daytime wetting	☐	☐	☐	☐	☐
Has soiling	☐	☐	☐	☐	☐

Substance Use

How many alcoholic drinks a day does the patient consume and what kind? _____

_____

At what age did the patient start drinking? _____ When was the patient's last drink of alcohol? _____

Has the patient ever experienced problems due to alcohol consumption, and if so, please describe: _____

_____

_____

Is there a family problem of alcohol abuse, and if so, please describe: _____

_____

Has the patient ever used any of the following:
☐Marijuana ☐Heroine ☐Cocaine/Crack ☐LSD ☐Ecstasy ☐Methamphetamines ☐Hallucinogens
☐Other non-prescribed drugs, please describe: _____

If the patient has used any of the above, please indicate frequency of use, age of first use, and describe any treatment:
_____

_____

Has the patient received any treatment for alcohol or other substance use? ☐Yes ☐No
If yes, please describe: _____

_____

Does the patient smoke cigarettes, pipes, cigars, or chew tobacco? ☐Yes ☐No
If yes, please describe frequency and amount: _____

Legal

Has the patient had any involvement with the legal system? ☐Yes ☐No

Is the patient currently on parole? ☐Yes ☐No

Is the patient current on probation? ☐Yes ☐No

If the patient has had involvement with the legal system, please describe each incident, including the reason for involvement, if the patient was arrested, on what charge the patient was arrested, and what was the outcome of a trial. Please include each length of incarceration.

Other Concerns

Early Childhood history:

Did your birth mother have any complications with her pregnancy with you or the delivery?

☐No ☐Yes Specify:

Did you meet your developmental milestones on time as a child (i.e. walking on time, talking on time, etc.)?

☐No ☐Yes Specify:

Please use the following space to write in any additional concerns that were not addressed in this questionnaire.

Thank you for completing this form. It is hoped that this information will help us perform our evaluation with a better understanding of the patient's presenting problems and reason for referral.