PATH Psychology Assessment *and* Treatment Services *of* Halton
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Adult Medical/Developmental History Form

Name: _____DOB: _____Age: _____

Gender: _____ Pronoun(s): _____

Home Address: _____

Phone: Home: _____ Cell: _____ Work: _____

Place of Birth: _____ Where did you grow up? _____

Today's Date: _____This form was completed by: _____

Emergency Contact (Relationship): _____Phone: _____

Presenting Circumstances

Reason for Referral: _____

_____

How long ago did your problem(s) begin? _____

What important events, if any, happened at about the same time that your problems began? _____

_____

Family Background

Relationship Status (Circle one): Single Committed Relationship
Married Re-married
Divorced Separated Widowed

Below list all of the people with whom you are currently living, their relationship to you (e.g. partner, son, sister, adopted brother, etc.).

Name/Age	Relationship to you
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Of the people in your life, do any have problems that concern you? Please explain.

_____

_____

_____

Pregnancy (of mother)

Duration of pregnancy (weeks) _____ (full term = 40 weeks) Mother's age at time of pregnancy _____

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

□ Excessive vomiting	□ Toxemia	□ Threatened miscarriage
□ Spotting/bleeding	□ Anemia	□ High blood pressure (hypertension)
□ Infections	□ Physical injury	□ Drinking (how much? _____)
□ Trauma (physical/mental)	□ RH incompatibility	□ Smoking (how much? _____)
□ Toxic exposure	□ Diabetes	□ Drug abuse (which drugs? _____)

Surgeries during pregnancy? Yes □ No □

Specify: _____

Other illnesses during pregnancy: _____

Medications taken during pregnancy: _____

Other significant events, complications, or diagnostic procedures? (please explain) _____

_____

Delivery

Labour: Spontaneous □ Induced □ Duration (hours) _____

Delivery: Vaginal □ Breech □ C-Section □

Birth weight: _____ pounds _____ ounces APGAR scores (if known) _____

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, NICU, etc.) _____

Did you have:

□ Problems latching/sucking	□ Problems growing	□ Excessive sleep
□ Feeding problems	□ Unusual stiffness	□ Problems sleeping
□ Problems swallowing	□ Milk allergies	□ Other allergies

□ Other _____

What is known about your behaviour, mood, and temperament for the first 2 years of life? _____

_____

Who was your main caretaker as an infant? _____

Did you have any early medical problems? If yes, please describe _____

_____

Developmental Progression

Were there any delays in your development? Check all that apply.

☐ Motor development (crawling, walking, using scissors, printing) ☐ Toilet training

☐ Language development (using words, sentences)

If yes, please explain _____

_____

Developmental milestones (age achieved, please be as precise as possible):

First words _____ Sentences _____ Walking _____ Bladder trained (day) _____

Bladder trained (night) _____ Bowel trained _____

Were any of the following present to an **unusual** degree during the **first 6 years** of life?

Please check those that apply and explain as necessary:

☐ Allergies	☐ Colic	☐ Ear infections	☐ Tubes (for ear infections)
☐ Eating problems	☐ Poor weight gain	☐ Drooling	☐ Clumsy, uncoordinated
☐ High fevers	☐ Headaches	☐ Lethargic	☐ Unusual number of accidents
☐ Head banging	☐ Restless	☐ Aggressive	☐ Poisoning/toxic exposure
☐ Disrupted sleep	☐ Thumb sucking	☐ Not easily calmed	☐ Nightmares/night terrors
☐ Difficult to console	☐ Easily agitated	☐ Unusually active	☐ Self-stimulation
☐ Irritability	☐ Unresponsive	☐ Into everything	☐ Abnormal height or weight
☐ Bedwetting	☐ Unusual fears	☐ Stuttering	☐ Difficulty pronouncing words
☐ Sleepwalking	☐ Nail biting	☐ Climbing	

☐ Other _____

Explain any of these problems _____

Are you: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

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

_____

Have any of your **siblings** experienced problems of development or mastery skills? ☐ Yes ☐ No

Explain: _____

As a child, how did your parents reward you? _____

As a child, how did your parents discipline you? _____

Family History (Parents or Guardians, Siblings)

Mother (or Parent 1) _____ Living? ____ Age (or date of death) _____

Highest level of education achieved: _____ Occupation: _____

Learning issues _____ Behavioural/psychiatric issues _____

Health (any issues): _____

Have any of your maternal blood relatives experienced problems similar to those you are currently experiencing? If so, please describe _____

_____

Father (or Parent 2) _____ Living? ____ Age (or date of death) _____

Highest level of education achieved: _____Occupation: _____

Learning issues _____ Behavioural/psychiatric issues _____

Health (any issues): _____

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**. (use back of questionnaire if you require more room)

Name	Age	Medical/Social/School problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any relatives who experienced any of the following? (check all that apply and the relation to you, e.g. uncle, cousin, grandmother, etc.)

Issue	Parent 1 side	Parent 2 side
☐ Learning problems	_____	_____

□ Attention/concentrations problems _____ | _____

□ Autism _____ | _____

□ Anxiety _____ | _____

□ Obsessive Compulsive Disorder _____ | _____

□ Unreasonable fears (phobias) _____ | _____

□ Depression _____ | _____

□ Suicide (or attempt) _____ | _____

□ Alcoholism _____ | _____

□ Drug abuse _____ | _____

□ Intellectual Disability _____ | _____

□ Schizophrenia _____ | _____

□ Manic Depression/Bipolar _____ | _____

□ Alzheimer's/Dementia _____ | _____

□ Anorexia/Bulimia _____ | _____

□ Psychiatric hospitalization _____ | _____

□ Other (please describe) _____ | _____

_____

Medical/Personal History

Have you ever had a seizure? □ Yes □ No If yes, with fever? _____ without fever? _____

Have you ever had a head injury, fainted, or lost consciousness? □ Yes □ No

If yes, please explain_____

Any surgeries? _____

Hospitalizations? _____

Temperature over 104° F? _____

Current Medications	Dosage	Reason Prescribed	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? □ Yes □ No If yes, how much? _____

Have you quit smoking? □ Yes □ No If yes, when did you stop? _____

How much alcohol do you drink? _____

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?

_____

Have you experienced any of the following? (check all that apply)

□ Abuse (physical, emotional, sexual)
□ Sexual Assault
□ Death of someone close to you
□ Alcohol or drug abuse by a partner or important relative
□ Witnessed violence or abuse of others in the home
□ Serious illness or disability in someone close to you
□ Other situations that may have been traumatic for you
□ Suicide threats
□ Trouble with the law
□ Depression
□ Violent behaviour

Explain: _____

_____

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

Behavioural:

□ Hyperactivity
□ Impulsivity
□ Irritability
□ Interrupting frequently
□ Sudden acts of aggression
□ Risk-taking
□ Acting as if "driven by a motor"
□ Temper outbursts
□ A "different person"
□ Disorganized/balancing checkbook difficulty
□ Accident prone
□ Nail-biting
□ Weakness
□ Energy level

Cognitive:

□ Tics/twitching
□ Sleep issues/sleepwalking
□ Uncoordinated/clumsiness
□ Reading/writing difficulty
□ Not listening
□ Poor memory
□ Not thinking logically
□ Problems not understanding jokes
□ Problems finding the "right" word/speech
□ Poor awareness of time
□ Poor attention span/concentration
□ Problems expressing thoughts or ideas
□ Difficulty finishing tasks
□ Difficulty listening

□ Anxiety
□ Aggression/Anger
□ Depression
□ Social withdrawal
□ Pain
□ Problem expressing emotion
□ Not learning from mistakes/experiences
□ Getting lost easily/sense of direction
□ Ask for repetitions often
□ Other _____

Psychiatric History

Have you sought **mental health treatment** (including hospitalization) before? _____

If yes, please list the professional, reasons for treatment, and dates seen.

Name of MH Professional	Reasons for Treatment	Dates Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had psychological testing completed? When, by whom, diagnosis (if applicable)?

_____

_____

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

Name	Specialty	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you noticed any problems with your sense of:

□ vision □ hearing □ smell □ taste □ touch

Please rate the amount of stress you are currently experiencing.

	Little or none						Extreme	
At home:	1	2	3	4	5	6	7	N/A
At work:	1	2	3	4	5	6	7	N/A
With extended family:	1	2	3	4	5	6	7	N/A
With friends:	1	2	3	4	5	6	7	N/A
With neighbours:	1	2	3	4	5	6	7	N/A

Educational/Occupational Information

What is the last grade/level of schooling that you completed? _____

If you did not complete school, what were your reasons for not completing school? _____

_____

What were your best subjects in school? _____

What were your worst subjects in school? _____

Have you ever been diagnosed with a learning disability? □ Yes □ No If yes, what areas? _____

_____

Are you currently working? □ Yes □ No If yes, what are you doing? _____

_____

What kinds of jobs have you held in the past? How did you feel about them? _____

_____

If you have left any jobs or changed positions, what were the reasons? _____

_____

What kind of work do you hope to do in the future? _____

_____

Have you ever been involved with the criminal justice system? _____

Are you currently involved in any lawsuits or legal actions? _____

Recreational/Personal

How do you enjoy spending your time? _____

_____

Please list the leisure activities that you most enjoy. _____

_____

Special abilities/interests _____

_____

What do you see as your strengths? _____

_____

What do you see as your weaknesses? _____

_____

List the benefits you hope to derive from the services we provide. _____

_____

_____

In addition to this history form, the additional information that was requested during the initial telephone conversation would also be helpful. This includes your medical records, if relevant, and preschool and/or school records, including evaluation reports by school personnel. If you had any evaluations outside of the school (e.g. OT, SLP, etc.), we would appreciate copies of these, as well.

Please add any other information that you feel is important in understanding you. Thank you.